Whole Kids Health

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Referral Form

Please fax the completed form along with any relevant Health Records to **647-777-6139.**

Referring Physician/Provider

Physician/Provider Name: _____

Phone: _____ Email: _____

Address: _____

Patient Information

Please provide the following patient background information.

Last Name: _____ First Name: _____

DOB: _____ Parent Name: _____

Address: _____

Phone: _____ Email: _____

☐ Consent to contact by phone
☐ Consent to leave voicemail

☐ Consent to email communication

Reason for Referral

☐ Therapy
☐ Assessment
☐ Parent Coaching
☐ Needle Fears Group
☐ Health Psychology Services

Brief Medical History/ Diagnoses/ Medications

☐ I acknowledge that the patient (and/or their parent or guardian, if applicable) is aware of this referral and has consented to being contacted by Whole Kids Health

Signature: _____ Date: _____