HEALTH COLLABORATIVE
Dr. M. Coons

Referral Form

PATIENT FIRST NAME

PATIENT LAST NAME

DATE OF BIRTH (mm/dd/yyyy)

PARENT/GUARDIAN FIRST NAME

PARENT/GUARDIAN LAST NAME

TELEPHONE NUMBER

EMAIL ADDRESS (OPTIONAL)

REASON FOR REFERRAL (check all that apply)

- ☐ Diagnostic Assessment (e.g., Query mood disorder, insomnia)
- ☐ Treatment

PROBLEM AREAS (check all that apply)

- ☐ Adjustment to life changes and stressors
- ☐ Anxiety
- ☐ Chronic Pain
- ☐ Chronic Disease Self-Management (e.g., diabetes burnout)
- ☐ Eating Problems
- ☐ Grief
- ☐ Mood Disorders
- ☐ OCD

PROBLEM AREAS (continued)

- ☐ Rehabilitation from injury/ illness
- ☐ Sexual Dysfunction (male)
- ☐ Sexual Identity
- ☐ Sleep (e.g., Insomnia)
- ☐ Stress Management
- ☐ Substance Use
- ☐ Weight Management/ Bariatrics

REFERRING PHYSICIAN

REFERRING PHYSICIAN TELEPHONE #

Completed referrals can be faxed confidentially to Dr. Michael Coons at (905) 333-1936
Please include copies of available consultation notes