HEALTH COLLABORATIVE
Dr. M. Coons

Referral Form

PATIENT FIRST NAME

PATIENT LAST NAME

DATE OF BIRTH (mm/dd/yyyy)

STREET ADDRESS

CITY

TELEPHONE NUMBER

EMAIL ADDRESS (OPTIONAL)

REASON FOR REFERRAL (check all that apply)

- ☐ Assessment (for neuromodulation candidacy)
- ☐ Assessment (psychodiagnostic)
- ☐ Treatment

NATURE OF PAIN (Check all that apply)

- ☐ Musculoskelletal
- ☐ Neuropathic
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Headache/Migraine
- ☐ Cancer
- ☐ Amputation
- ☐ Other

CURRENT TREATMENTS (Check all that apply)

- ☐ Medications
- ☐ Psychological Treatents
- ☐ Physiotherapy
- ☐ Occupational Therapy
- ☐ Medical Marijuana
- ☐ Neuromodulation
- ☐ Surgical
- ☐ Other

OTHER COMPLAINTS (Check all that apply)

- ☐ Adjustment Problems
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Personality Problems
- ☐ Stress Management
- ☐ Substance Use
- ☐ Trauma/PTSD
- ☐ Relationship Problems

OTHER COMPLAINTS (continued)

- ☐ Diabetes
- ☐ Cardiovascular Disease
- ☐ Hypertension
- ☐ Rehab from Illness or Injury
- ☐ Self-Management Adherence
- ☐ Sexual Dysfunction
- ☐ Sleep Problems
- ☐ Weight Management/Bariatrics

FUNDING:

- ☐ WSIB
- ☐ Veterans Affairs
- ☐ Private Insurance
- ☐ Auto Accident Benefits
- ☐ Self Pay

REFERRING CLINICIAN

REFERRING CLINICIAN TELEPHONE #

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