CENTRE FOR COLLABORATIVE HEALTH

The Oakville Clinic

1011 Upper Middle Road East, Unit A7, Oakville ON, L6H 4L2
T: 905-849-9915 | www.cch-oakville.ca | info@cch-oakville.ca

GENERAL REFERRAL FORM

FAX this form and supporting documents to 905-849-6165

Please note that the clinic will contact the patient to set up an appointment date and time, and will also notify the referring doctor of these details.

Patient Information:

First Name: _____ Last Name: _____

Date of Birth: _____ Phone: _____

OHIP#: _____ Gender: _____

Referring Doctor's Information:

Name: _____ Designation: _____

Phone: _____ Fax: _____

Date of Referral:

Reason for Referral:

Services Required (check all that apply):

Core Services:

- ☐ Naturopathic Medicine
- ☐ Chiropractic Medicine
- ☐ Massage Therapy
- ☐ Nutrition/Dietitian Services
- ☐ Psychotherapy
- ☐ Collaborative Health Programs*

*****Our collaborative program includes team visits with two or more core practitioners – check this box (and two or more of the above) if your patient may benefit from this approach.

Additional Services:

- ☐ Acupuncture
- ☐ Intravenous (IV) Therapy
- ☐ Vitamin B12 Injection
- ☐ Bio-identical Hormone Therapy (BHRT)
- ☐ Meal planning
- ☐ Mindfulness therapy
- ☐ Orthotics
- ☐ Exercise/Physical therapy
- ☐ Electro-modalities (LASER, IFC, Ultrasound)
- ☐ Chronic Pain management

*Please attach any relevant labs/investigations to aid in the management of this patient.

Referring Doctor's Signature: _____