

Referral Form

Fax the completed form to (844) 927-0222

Please complete every section and fax it to (844) 927-0222, together with any assessment reports or other documents. Every question below is a form field: you can type into this PDF and print it, or print it and write.

You can also refer online at allbrainsclinic.com/referral/form/ — it asks the same questions, attaches reports directly, and reaches the clinic straight away.

Questions marked * are needed before the referral can be actioned.

| The patient

Patient first name *

Patient last name *

Date of birth *

YYYY-MM-DD

PHN *

The ten-digit BC Personal Health Number.

Cell phone *

Alternate phone

Email *

Address *

Address line 2

City *

Province *

Postal code *

For example V6M 3X4.

Guardian consent for email *

☐ Yes ☐ No

| Clinical background

Court, medical-legal or custody matters *

☐ Yes ☐ No

Details of legal matters

Only if you answered Yes above.

Previous diagnosis *

☐ Yes ☐ No

The previous diagnosis

Only if you answered Yes above.

Medications, past and current

Medication	Dosage	Date

Psychiatric and medical history

Reason for referral

Tick everything that applies.

Assessments requested *

- ☐ Autism Assessment
- ☐ Psychoeducational Assessment
- ☐ ADHD/ADD Assessment
- ☐ Early Social and Language Development
- ☐ Speech and Language Assessment
- ☐ Motor Development and Posture Assessment
- ☐ Occupational Therapy
- ☐ Unsure / General Inquiry

Services of interest

- ☐ Resource Liaison
- ☐ Parent Training
- ☐ Student Support Liaison
- ☐ Parents Coaching
- ☐ ADHD Coaching
- ☐ Picky Eating Online Consultation
- ☐ Occupational Therapy Online Consultation
- ☐ Cognitive Behavioural Therapy
- ☐ Acceptance & Commitment Therapy
- ☐ Couples Therapy
- ☐ Trauma Focused Therapy

You

Your name *

MSP billing number *

Your clinic address *

Your phone *

Your fax *

Your email

Optional. Where a reply about this referral should go.

I confirm that I am actively involved in this patient's care and can act on the recommendations All Brains Clinic makes. I understand that All Brains Clinic provides consultative care and does not assume ongoing care of this patient.

☐ I confirm the above. *

Name (printed) *

Signature *

Date *

YYYY-MM-DD

Please fax any other clinical or supporting documents to (844) 927-0222. If anything about this referral needs discussing, call (604) 998-2244.