REFERRAL FORM

Adult ADHD Assessment

Please fill out the below information and send by fax: 604-525-8124 or email ADHD@adultadhdcentre.com. The Adult ADHD Centre will contact the patient directly to set up an appointment. A consult report will be sent back to the referring healthcare provider.

Referring Physician or Nurse Practitioner:

First Name		**Last Name**	
Billing #		**Office Phone**	
Email		**Office Fax**	
Clinic Address	Street:	City:	Province:

Patient Information:

First Name		**Last Name**	
Preferred Name		**Gender**	
Pronouns		**DOB (mm/dd/yy)**	
Personal Health #		**Email**	
Home Phone		**Cell**	
Street Address		**Unit**	
City		**Province**	
Postal Code			

ANY RELEVANT PATIENT INFORMATION (Symptoms, Function, Challenges & Medication)
Current Medications: Symptoms: