Field Trip Health
hello@fieldtriphealth.ca

Fax Number: 855-933-1211

Client Referral Form

Clinician Information		
Referring Clinician:	Phone:	Fax:
Clinician Signature:	Address:	College Number: Billing Number:
Family Physician:	Phone:	Fax:

Patient Information		
Last Name:	First:	Middle:
DOB:	PHN/Health Card Number:	
Address:		
City:	Province:	Postal Code:
Cell Phone: (required)	Alternate Phone:	Email (required):

Treatment Referral	Primary Indication(s)
Psychedelic-assisted therapy ☑ Chronic pain management ☐ Repetitive Transcranial Magnetic Stimulation (rTMS) ☐	Depression ☐ Anxiety ☐ PTSD ☐ OCD ☐ Addiction ☐ Eating Disorder ☐ Other ☐
Relevant clinical information:	

Additional Patient Information		
Medications tried (if known):	Medications patient is currently on:	Past medical history:
Contraindications: Uncontrolled hypertension ☐	Psychosis ☐	None ☐

***Please fax referral when complete**