Field Trip Health
hello@fieldtriphealth.ca

Fax Number: 855-933-1211

Patient Referral Form

Provider Information		
Referring Provider Name: ☐ MD ☐ NP	Phone:	Fax:
Provider Signature:	Address:	College Registration 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):
CC Doctor for Consultation Letter:	Address:	Phone:

Treatment Referral	**Primary Indication(s)**
☐ Consultation for Ketamine Assisted Psychotherapy program eligibility ☐ Consultation for Ketamine for pain management ☐ Repetitive Transcranial Magnetic Stimulation (rTMS) (Vancouver only)	☐ 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 ☐ Pregnancy ☐ None ☐