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REFERRAL FORM

Please fax at 905-230-4014

REFERRING PHYSICIAN: _____

PHONE: _____ **FAX:** _____

NAME OF THE PATIENT: _____

PHONE _____

REASON FOR REFERRAL

Please advise if there is any evidence of elevation of endocrinological or haematological Abnormalities

DATE: _____

SIGNATURES: _____

Note: The services are not covered under OHIP. However, psychological services are eligible for coverage under extended health care plans. If you have a health care plan it is recommended you check with your plan provider to determine the extent of your coverage for the services of the psychologist.

