DR. OMID YAHYAZADEH, MD

SUPREME MEDICAL CLINIC

BOARD-CERTIFIED FAMILY PHYSICIAN

Comprehensive Experience in Mental Health Care | 20+ Years Clinical Experience

REFERRAL FORM

ADDRESS
Yonge & Sheppard
5B-4773 Yonge St, North York, ON M2N 0G3

PHONE
416-477-6090

FAX
416-247-7393

EMAIL
dr.oyahyazadeh@gmail.com

REFERRAL FORM

Please fax the completed referral to 416-247-7393

1 PATIENT INFORMATION

LAST NAME

FIRST NAME

DATE OF BIRTH (YYYY/MM/DD)

HEALTH CARD #

PHONE

ALTERNATE

EMAIL

ADDRESS

2 REASON FOR REFERRAL

Check all that apply

- ☐ Anxiety / Stress
- ☐ Depression
- ☐ ADHD
- ☐ Insomnia / Sleep Difficulty
- ☐ Mood Disorders
- ☐ Medication Review / Management
- ☐ Psychotherapy / Counselling
- ☐ Other

3 RELEVANT CLINICAL INFORMATION

PRIMARY CONCERN / SYMPTOMS

DURATION

CURRENT MEDICATIONS

PAST PSYCHIATRIC HISTORY

RELEVANT MEDICAL HISTORY

OTHER NOTES / ATTACHMENTS

4 REFERRING PROVIDER INFORMATION

REFERRING PROVIDER NAME

PRACTICE / FACILITY

ADDRESS

PHONE

FAX

EMAIL

5 URGENT REFERRAL

- ☐ Urgent (within 7 days)
- ☐ Non-Urgent

6 PREFERRED CONTACT METHOD

- ☐ Phone
- ☐ Fax
- ☐ Email

REFERRAL AUTHORIZATION

REFERRED BY (SIGNATURE)

DATE

Thank you for your referral and trust in our care.

We look forward to supporting your patient's health and well-being.