

FAX



Suite 401 505-8840 210 St

Langley, BC V1M 2Y2

www.greenleafmc.ca

TO: +19725329272	Date: 01/22/2026
From: Greenleaf Medical Clinic	Phone: (604) 371-4769
Fax: (604) 371-2044	Pages: 2

Comments

Returns fax it receives - testing service



PATIENT REFERRAL FORM

☐ URGENT ☐ SEMI-URGENT

Suite 401 505-8840 210 St
 Langley, BC V1M 2Y2
 t: (604) 371-4769
 f: (604) 371-2044
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PHYSICIAN INFORMATION

Referring Physician:	Phone:	Fax:
Billing #:		
Family Physician:	Phone:	Fax:

PATIENT INFORMATION

Last Name:	First :	Middle:	Sex: ☐ M ☐ F
Date of Birth: (dd/mm/yyyy)		Personal Health Number:	
Address:	City:	Province:	Postal Code:
Home Phone:	Cell Phone:	Email:	

PATIENT MEDICAL HISTORY

MENTAL HEALTH CONDITIONS

- | | | |
|---|--|---|
| ☐ ADD/ADHD | ☐ Bi-Polar | ☐ PTSD |
| ☐ Anxiety | ☐ Depression | ☐ Sleep Disorder |
| ☐ Autism/Developmental Delay | ☐ Eating Disorder | ☐ Schizophrenia |

GASTROINTESTINAL CONDITIONS

- | | | |
|-----------------------------------|--|---|
| ☐ Appetite | ☐ Crohn's Disease | ☐ Irritable Bowel Syndrome |
| ☐ Colitis | ☐ Hepatitis | ☐ Nausea |

NEUROLOGICAL/PAIN CONDITIONS

- | | | |
|---|---|---|
| ☐ Alzheimer's Disease | ☐ Complex Regional Pain Syndrome | ☐ Parkinson's Disease |
| ☐ Arthritis-Osteoarthritis | ☐ Degenerative Disc Disease | ☐ Pelvic Pain/Endometriosis |
| ☐ Arthritis-Rheumatoid Arthritis | ☐ Epilepsy/Seizures | ☐ Post Surgical Pain |
| ☐ Back & Neck Pain | ☐ Fibromyalgia | ☐ PMS/Menstrual Cramps |
| ☐ Bladder Pain | ☐ Glaucoma | ☐ Repetitive Strain Injury |
| ☐ Brain/Head Injury/Concussion | ☐ Jaw Pain | ☐ Spinal Cord Injury/Disease |
| ☐ Central Sensitivity Syndrome | ☐ Migraines | ☐ Trauma |
| ☐ Chronic Pain/Neuropathic Pain | ☐ Muscle Spasms | |

CANCER CONDITIONS

- | | |
|-----------------------------------|---------------------------------|
| ☐ Appetite | ☐ Nausea |
| ☐ Cancer | ☐ Pain |

MISC./OTHER CONDITIONS

- | | | |
|---|-----------------------------------|------------------------------------|
| ☐ Chronic Fatigue Syndrome | ☐ HIV/AIDS | ☐ Menopause |
| ☐ Fatigue | ☐ Libido | ☐ POTS |
| ☐ Other | | |

Please select medication that has been tried:

- | | | | | |
|--|---|-----------------------------------|-----------------------------------|--|
| ☐ Gabapentin/Lyrica | ☐ Muscle Relaxants | ☐ Opioids | ☐ NSAIDS | ☐ SSRI |
| ☐ IV Lidocaine | ☐ IV Ketamine | ☐ Nabalone | ☐ Tramadol | ☐ Amitriptyline/Nortriptyline |

Does the patient have any UNCONTROLLED mania, schizophrenia, depression, using sedatives/hypnotics/other psychoactive drugs?

☐ Yes ☐ No

DO SEND: List of medications. Any injury or disease relevant imaging such as XRay, CT, MRI etc. As well as relevant consults (psych, neuro, rheum and surgical.) **DO NOT SEND:** Bloodwork results.

Other Medical History:

Email referral to: fax@greenleafmedicalclinic.ca OR Fax referral to 1-604-371-2044

Physician Signature:

Date: