FAX

Greenleaf
MEDICAL CLINIC

Suite 401 505-8840 210 St
Langley, BC V1M 2Y2
www.greenleafmc.ca

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

Comments

The standard Lorem Ipsum passage, used since the 1500s

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Greenleaf MEDICAL CLINIC

PATIENT REFERRAL FORM

☐ URGENT ☐ SEMI-URGENT

Suite 401 505-8840 210 St
Langley, BC V1M 2Y2
t: (604) 371-4769
f: (604) 371-2044
www.greenleafmc.ca

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

GASTROINTESTINAL CONDITIONS

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

NEUROLOGICAL/PAIN CONDITIOINS

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

CANCER CONDITIONS

☐ Appetite
☐ Cancer
☐ Nausea
☐ Pain

MISC./OTHER CONDITIONS

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

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:**