

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
www.greenleafmc.ca

PHYSICIAN INFORMATION

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

Last Name:	First :	Middle:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Date of Birth: (dd/mm/yyyy)	Personal Health Number:		
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Address:	City:	Province:	Postal Code:
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Home Phone:	Cell Phone:	Email:
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PATIENT MEDICAL HISTORY

MENTAL HEALTH CONDITIONS

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Bi-Polar	<input type="checkbox"/> PTSD
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Sleep Disorder
<input type="checkbox"/> Autism/Developmental Delay	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Schizophrenia

GASTROINTESTINAL CONDITIONS

<input type="checkbox"/> Appetite	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Irritable Bowel Syndrome
<input type="checkbox"/> Colitis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Nausea

NEUROLOGICAL/PAIN CONDITIONS

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

CANCER CONDITIONS

<input type="checkbox"/> Appetite	<input type="checkbox"/> Nausea
<input type="checkbox"/> Cancer	<input type="checkbox"/> Pain

MISC./OTHER CONDITIONS

<input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Menopause
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Libido	<input type="checkbox"/> POTS
<input type="checkbox"/> Other		

Please select medication that has been tried:				
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<input type="checkbox"/> Gabapentin/Lyrica	<input type="checkbox"/> Muscle Relaxants	<input type="checkbox"/> Opioids	<input type="checkbox"/> NSAIDS	<input type="checkbox"/> SSRI
<input type="checkbox"/> IV Lidocaine	<input type="checkbox"/> IV Ketamine	<input type="checkbox"/> Nabilone	<input type="checkbox"/> Tramadol	<input type="checkbox"/> Amitriptyline/Nortriptyline

Does the patient have any UNCONTROLLED mania, schizophrenia, depression, using sedatives/hypnotics/other psychoactive drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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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:
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