

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: <input type="checkbox"/> M <input type="checkbox"/> 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

- | | | |
|---|--|---|
| <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:

- | | | | | |
|--|---|-----------------------------------|-----------------------------------|--|
| <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"/> Nabalone | <input type="checkbox"/> Tramadol | <input type="checkbox"/> 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: