All Brains Clinic

WHERE COMMUNITY MEETS CARE

Referral Form

After completing the form, please fax it to (844) 927-0222.

Patient's Contact Information

Patient first name *

Patient last name *

Date of birth *

YYYY-MM-DD

PHN *

The ten-digit BC Personal Health Number.

Cell phone *

Alternate phone

Email *

Address *

Address line 2

City *

Province *

Postal code *

For example V6M 3X4.

Guardian consent for email communication *

○ Yes ○ No

Are there current court/medical legal and/or custody matters? *

○ Yes ○ No

If "Yes", provide details

Only if you answered Yes above.

Previous diagnosis *

○ Yes ○ No

If "Yes", identify diagnosis

Only if you answered Yes above.

Medication and Dosage (Past and current)

Medication	Dosage	Date

Psychiatric/Medical History

Reason for Referral (Indicate all that apply)

Assessments *

- ☐ Comprehensive Autism Assessment and any accompanying comorbid psychiatric disorder.
- ☐ In-depth Psychoeducational Assessment and any accompanying comorbid psychiatric disorder.
- ☐ Multi-disciplinary ADHD/ADD Assessment and any accompanying comorbid psychiatric disorder.
- ☐ Early Language and Social Development Assessment and any accompanying comorbid psychiatric disorder.

Therapies

- ☐ ADHD (e.g. Coaching, CBT)
- ☐ Learning Disabilities (e.g. evidence-based tutoring)
- ☐ Anxiety, Depression (e.g. CBT)
- ☐ Tic Disorders and Tourette Syndrome (e.g. Comprehensive Behavioural Intervention for TICS)
- ☐ Family Conflict (e.g. Parenting Strategies/Support)
- ☐ Emotional and Behavioural Regulation (e.g. DBT)
- ☐ Occupational Therapy
- ☐ Career Coaching

Physician's Information

Name *

Billing Number *

Address *

Phone Number *

Fax Number *

Email

Optional. Where a reply about this referral should go.

I confirm that I am actively involved in this patient's care and can act on the recommendations All Brains Clinic makes. I understand that All Brains Clinic provides consultative care and does not assume ongoing care of this patient.

☐ **I confirm the above.** *

Name (printed) *

Signature *

Date *

YYYY-MM-DD

Please fax any other clinical or supporting document to (844) 927-0222.