



**REFERRAL FORM**  
**ADULT ADHD ASSESSMENT**  
**OHIP and MSP only**

Please fill out the below information and send by fax: 604-525-8124 or email ADHD@adultadhdcentre.com. The Adult ADHD Centre will contact the patient directly to set up an appointment. A consult report will be sent back to the referring healthcare provider.

Select Public Health Coverage:   OHIP       MSP

**Referring Physician or Nurse Practitioner:**

<b>First Name</b>		<b>Last Name</b>	
<b>OHIP/MSP Billing #</b>		<b>Office Phone</b>	
<b>Email</b>		<b>Office Fax</b>	
<b>Clinic Address</b>	Street:	City:	Province:

**Patient Information:**

<b>First Name</b>		<b>Last Name</b>	
<b>Preferred Name</b>		<b>Gender</b>	
<b>Pronouns</b>		<b>DOB (mm/dd/yy)</b>	
<b>Personal Health #</b>		<b>Email</b>	
<b>Home Phone</b>		<b>Cell</b>	
<b>Street Address</b>		<b>Unit</b>	
<b>City</b>		<b>Province</b>	
<b>Postal Code</b>			

**ANY RELEVANT PATIENT INFORMATION (Symptoms, Function, Challenges & Medication)**

Current Medications:

Symptoms: