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Physician's Referral Form

Patient's Name: _____ □M □F Age: ____ DOB: _____ DD/MM/YYYY Health Card #: _____ VC

Parent's Name: _____ Phone #: _____

Referring Physician: _____ Referral #:_____ Fax #:_____

Date of last Physical Exam: _____ Height _____ Weight _____ BP_____ HR _____

Current Medical Problems:_____

_____

Current Medications:_____

_____

Allergies:_____

Reason for Referral - What's Your Question?

_____

_____

_____

_____

_____

_____

_____

_____

How long have you known this child? <1 yr. ___ 1-3 yrs. ___ 3-5 yrs. ___ 5-10 yrs. ___ >10 yrs. ___

Your impression of the Severity of the child's symptoms **at the time of this referral:**

1	Minimal / Probably normal	3	Mild	5	Severe
2	Occasional / Episodic	4	Moderate	6	Disabling

Has the Parent's Questionnaire been given to the patient or have they been told how to access it from my website (www.doctortempleman.com).

YES _____ NO _____

Are they aware that they MUST complete it and return it to our office if they want an appointment to be scheduled?

YES _____ NO _____