Don Valley
INTEGRATED DIGESTIVE CLINIC

REFERRAL FORM

PATIENT INFORMATION

NAME: _____

GENDER: ____ DATE OF BIRTH (DD/MM/YY): _____

ADDRESS: _____

CITY, POSTAL CODE: _____

PHONE #: _____

REFERRING DOCTOR

NAME: _____

ADDRESS: _____

CITY, POSTAL CODE: _____

PHONE #: _____

FAX #: _____

CHIEF CONCERN(S):

_____

_____

REFERRAL TO

Tick box for discipline(s) and/or services you are referring to

Services Offered:

- ☐ NUTRITIONAL & DIETARY ASSESSMENT
- ☐ MEAL PLANNING
- ☐ PELVIC HEALTH REHABILITATION
- ☐ VISCERAL MANIPULATION
- ☐ ACUPUNCTURE / ELECTROACUPUNCTURE
- ☐ PSYCHOTHERAPY / CBT / MINDFULNESS BASED THERAPY
- ☐ MASSAGE THERAPY
- ☐ INFUSION THERAPY (BIOLOGICS)
- ☐ LABORATORY BLOOD DRAW (Please include requisition form)
- ☐ UREA BREATH TEST (Please include requisition form)

Complementary Health Care Practitioners:

- ☐ NATUROPATHIC DOCTOR
- ☐ REGISTERED DIETITIAN
- ☐ PELVIC FLOOR PHYSIOTHERAPIST
- ☐ REGISTERED PSYCHOTHERAPIST
- ☐ OSTEOPATH
- ☐ REGISTERED MASSAGE THERAPIST

ALLERGIES / INTOLERANCES / SENSITIVITIES:

_____

HOW DID YOU HEAR ABOUT DON VALLEY DIGESTIVE?

_____

*** Please include a copy of all relevant blood work results, consult notes, and test results.

SIGNATURE: _____ DATE: _____

REFFERAL FORMS CAN BE FAXED TO: 647.497.6006

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info@DonValleyDigestive.com | P: 647.341.4517 | F: 647.497.6006