OWL POD

DREAM BIGGER

VIRTUAL TELEMEDICINE MENTAL HEALTH CLINIC

# REFERRAL FORM

Last, First Name: _____

PHN: _____

Email: _____

(EMAIL IS REQUIRED)

DOB: _____

Phone #: _____

## Reason for referral

☐ Stress ☐ Weight management

☐ Depression ☐ Grief

☐ Anxiety ☐ Insomnia

## Is your patient interested in group therapy

☐ Yes ☐ No

## Referring Physician

Name: _____

PRAC ID: _____

Phone #: _____

Fax #: _____

## Family Physician (If different from referring Physician)

Name: _____

PRAC ID: _____

Phone #: _____

Fax #: _____

- If you are NOT the patients family doctor, please add Family Doctor details, including name, clinic and fax number
- Owl Pod does phone or video appointment only
- If your patient has a history of mania, psychosis, suicidal ideation/attempts, we request that they are stable
- We are not a crisis mental health service.
- We accept referrals for patients age 16 and up

## Contact us:


1 833 695 7637

(587) 317-9978

www.owlpod.ca


You can send an e-consult request with **owlpod@therapysecure.com** or by AVA EMR.

Incomplete patient demographics referring doctor and family doctor details will be considered an incomplete referral and will be returned.