Dr. Amy Andrews-Alexander

Referral Form – New Patients :: **Please fax to: 647.776.7779**

Date: ___________________________

Referring Clinician (any clinician) Information:

Name:	Billing #:
Phone:	Fax:
Family Physician (if different):	Family Physician fax:

Patient Information:

Name:	OHIP w/ VC:
DOB:	Fax:
Best email contact:	Best phone contact:

Patient Requires assessment for the following Group Service(s): (please circle one or more):

- Vital Recovery: Mindful Medicine for Coping with Major Illness (8-10 weeks)
- Living with Ease: Mindful Medicine for Chronic Pain (10 weeks)
- CBT-I: Cognitive Behavioural Therapy for Insomnia (5 weeks)

Psychiatric History:

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Medical History:

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Current Medication(s):

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Please fax this form ***along with*** any ***relevant specialist consultation notes***, if available.

Please ensure that patients are aware that this referral is for a GROUP PROGRAM and that a *fully-refundable deposit* will be required to secure their registration.

Please direct patients to www.dramyalexander.com/current-groups for further details.

Clinician's Signature: ____