VERIDIAN WELLNESS CLINICS (VWC) PATIENT REFERRAL FORM

PATIENT INFORMATION

First Name: ______________________________

Last Name: ______________________________

Date of Birth (mm/dd/yyyy): ______________________________

Personal Health Number (PHN): ______________________________

Province of PHN (Quebec not accepted): ______________________________

Phone number: ______________________________

Address: ______________________________

City: ______________________________

Province: ______________________________

Postal Code: ______________________________

Email (Mandatory): ______________________________

REFERRING PHYSICIAN INFORMATION

Name of referring physician: ______________________________

BC MSP#: ______________________________

Phone number: ______________________________

Fax number: ______________________________

Address: ______________________________

Referrals with insufficient information will be sent back for correction

REASON FOR REFERRAL

*One reason for referral per form. If more than one reason for referral is needed, please complete separate referral forms. Forms with more than one reason for referral will be sent back to the referral physician/NP to be corrected and re-sent. Follow up provided only if appropriate for VWC.

☐ ADHD Diagnostic Assessment for adults

☐ Repeated Trancranial Magnetic Stimulation (rTMS)

- Select this for patients with: depression (non-bipolar depression & bipolar depression), anxiety, post COVID19 brain fog
- Patients will receive an assessment on their depression and/or anxiety, whether the patient is suitable for rTMS, and other recommendations (ex. pharmacotherapy or psychotherapy recommendations) to optimize the patient's symptoms

☐ Rapid Access Mental Health Assessment

- Combined psychiatric & psychological assessment with recommendation for patient

Dr. Jay Wang, MD, FRCPC
Veridian Wellness Clinics
506 – 4211 Kingsway Burnaby BC V5H1Z6
Phone: 7783662661 Fax: 6042275471

VERIDIAN WELLNESS CLINICS

Narrative description of reason for referral:

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Please include applicable clinical information (ex. investigations, past consultation and clinical notes)

PLEASE CHECK THE FOLLOWING TO ACKNOLWEDGE:

☐ The referring physician agrees to remain as MRP

☐ The patient has been informed that there is a cost for any uninsured services that is not covered by BC MSP

☐ The patient has been informed of missed appointment fee policy of the Veridian Wellness Clinics (refer to https://www.veridianwellnessclinics.com/), and aware that the rate of the missed appointment fees are subject to change

☐ The patient has been informed that a consultation does not guarantee on-going follow-up; follow-up are provided based on patient suitability and the resources available at the clinic

☐ referring physician/NP agrees not to make referrals with the following elements: child & adolescents aged 19 and under), patients with major cognitive impairments, patients with psychosis, patients with complex care needs, patients with primary complaints in the areas of neurodevelopmental disorder such as autism or learning disabilities other than ADHD, sexual medicine, history of significant head trauma, MCFD involvements, patients with on-going litigations/legal involvements, patients of no-fixed address, patients with primary personal disorders, patients with history of physical and verbal violence & aggressions

Referring physician signature: ____

Date of Referral: ____

Please fax all consultation request to the attention of:

Veridian Wellness Clinics

Dr. Jay Wang, MD, FRCPC

Fax: 6042275471