Telephone: 1-844-746-1738
Fax: 1-844-262-0947
referrals@naturalhealthservices.ca
www.naturalhealthservices.ca

Please select a clinic: ______________________________

(Calgary, Edmonton, Lethbridge, Medicine Hat, Saskatoon, Windsor, Winnipeg)

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*Referring Practitioner: ______________________ *PRAC ID #: ______________

*Referring Clinic Name: ______________________ *Phone: ______________

*Address: ______________________ Fax: ______________

*City: ______________ Province: ______________ Postal Code: ______________

*Email: ______________________ Website: ______________________

*Referring Practitioner's Signature: ______________________________

Patient Information:

*Patient Name: ______________________ *HC#: ______________

*DOB (yyyy/mm/dd): ______________ *Gender: ______________ Email: ______________

*Home Phone: ______________________ Cell Phone: ______________________

*Address: ______________________________

*City: ______________ Province: ______________ Postal Code: ______________

Reason for referral: ______________________________

***Information required in return (click all that apply):**

- ☐ Referral acceptance letter
- ☐ Appointment updates
- ☐ Chart notes
- ☐ Recommendations
- ☐ Dosage or g/day
- ☐ All of the above

*Receive updates by: ☐ Email ☐ Phone ☐ Fax

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