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☐ Dr. Kerry Mayrand ON-97818
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referrals@naturalhealthservices.ca
www.naturalhealthservices.ca

*Referring Practitioner: ____________________ *OHIP Billing #: ____________________

*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: ____________________

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***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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