Institute for Behavioural & Functional Medicine

OHIP REFERRAL FORM (MD/NP)

1. REASON FOR REFERRAL

CBT for

☐ **Insomnia** (CBT-i) ☐ **Chronic Fatigue** ☐ **Chronic Headache**

☐ **Lower Back Pain** ☐ **Hypertension** ☐ **Post-concussion Syndrome**

2. PATIENT'S EMAIL ADDRESS

_____

- ✓ NO ACCESS BONUS NEGATION
- ✓ OHIP-FUNDED
- ✓ VIRTUAL SERVICES AVAILABLE ONTARIO-WIDE

3. PATIENT'S DEMOGRAPHICS

(Or attach patient's demographics sticker)

Name _____

Date of birth (dd/mm/yy) _____

Address _____

City & Postal Code _____

Health Card Number _____

Phone Number _____

4. REFERRING MD/NP'S INFORMATION

MD/NP Name _____

MD/NP OHIP # _____

MD/NP Fax # _____

Date of Referral _____

ATTENTION FHO PHYSICIANS: Referral to us will not affect your access bonus.

Our physicians are specialists or have GP-Focused Practice Designations in Psychotherapy & Sports Medicine, allowing them to see patients without affecting your access bonus. To review the billing codes we use, visit https://ibfmed.ca/mds-nps/.

Please fax completed forms with relevant PMHx & list of current meds to 647-660-9355

Virtual Clinic https://ibfmed.ca | team@ibfmed.ca | Tel: 416-306-2001 | Fax: 647-660-9355