

REFERRAL FORM

NOTE: This is a virtual clinic that serves patients ages 13 and older in Ontario, Canada only.

PATIENT INFORMATION	
Full Name	
Date of Birth	
Email	
Phone	
OHIP (with version code)	
Reason for Referral	Consultation for chronic insomnia and possible treatment with the DECODE Insomnia Program

REFERRING PHYSICIAN INFORMATION			
Name			
Fax		Billing no.	
Other contact (optional)			
Signature		Referral Date	

Please fax the completed form to 647-689-7588