BreathControl
every one counts

Patient Referral Form

If you need assistance or would like to talk to us during regular business hours please call **250-667-7722**.
Please email **clinic@breathcontrol.ca** for an appointment or fax to **1 (250) 999-0438.**

Patient Information

Today's date:_____(dd/mm/yyyy)

Patient's name: _____ (Please print name clearly)

D.O.B: _____*(If under the age of 9 patient must be accompanied by a parent or guardian.)*

Phone: _____

Appointment Type: Virtual Telehealth ☐ In-Person ☐

Physician/Practitioner Information

Physician/Practitioner Name: _____

Address: _____

Phone: _____ Fax: _____

Please check one or more of the boxes below: *Primary referral (select multiple if applicable):*

☐ Pain Management / Injury Rehabilitation

☐ Concussion / Brain Injury

Traumatic Injury: ☐ Physical and/or ☐ Psychological

☐ Substance Use Disorder

☐ Insomnia / Sleep Disorder

☐ Dysautonomia / ANS Regulation

☐ Anxiety / Panic Disorder

☐ Depression

☐ Cardiac Health

☐ Respiratory Health

☐ Smoking cessation

☐ Diabetes

☐ Hepatic Health

☐ Grief

☐ Anger

☐ Other

Please Specify:

_____

Comments of note:

_____

_____

Referring Physician/Practitioner Signature _____

PLEASE ADVISE PATIENTS:

- Bring a list of all current medications to the appointment.
- On site free parking is available.
- Arrive at least 10 minutes prior to the appointment to fill out a short questionnaire and sign consent.
- Please provide at least 48 hours notice for any cancellations or changes to appointment times. Email the clinic at **clinic@breathcontrol.ca** or call **250-667-7722.**
- Additional information can be found on our website at **www.breathcontrol.ca.** Referral forms can also be downloaded from our website at **www.breathcontrol.ca/patient-referral**. You will be notified with the date and time of your patient's appointment. Your patient will be informed as well.

PLEASE FAX REFERRAL TO: **1 (250) 999-0438** or email to **clinic@breathcontrol.ca.**