Referral Form

Mindfulness-Based Interventions

Thank you for your referral. All participants must have a primary care physician & complete their registration at MindfulnessStudies.com

The Centre for Mindfulness Studies

Patient Information

***Required information**

*First Name: _____ *Date of Birth: M_____/D_____/Y_____

*Last Name: _____ *Email: _____

Address: _____ *Phone #: (_____)_____

_____ *OHIP #: _____

City: _____ OHIP VC: _____

Province: _____ Recommended Program/s (e.g. MBCT, CBT, etc.):

*Postal Code: _____ _____

Reason for Referral: _____

_____

Client History/Medications: _____

_____

_____

_____

Referral Source Information

*First Name: _____ *Referral Date: _____

*Last Name: _____ *Fax: (_____)_____

Organization: _____ *Phone: (_____)_____

Address: _____ Email: _____

_____ Designation (e.g. MD, NP): _____

City: _____ Province: _____ Specialty (if applicable): _____

*Postal Code: _____ Billing #: _____

Please send completed referral form to the Centre for Mindfulness Studies

by fax: (855) 344-9519 **or email:** info@mindfulnessstudies.com

180 Sudbury Street, Toronto, Ontario M6J 0A8

Phone: (647) 524-6216

MindfulnessStudies.com

Revised Aug 2016