

## Referral Form 2

Fax: 416-595-6399 Attention: **Eating Disorder and Addiction Clinic**

RE: Physician/Therapist Referral Form

Date: \_\_\_\_\_

The **Eating Disorders and Addiction Clinic** would be glad to consider your patient for treatment upon completion of this form.

Name and Credentials of referral source: \_\_\_\_\_

Name of Patient being referred: \_\_\_\_\_

Diagnosis:

Axis

- I \_\_\_\_\_
- II \_\_\_\_\_
- III \_\_\_\_\_
- IV \_\_\_\_\_
- V \_\_\_\_\_

Treatment/Issues of Concern (*use additional pages as necessary*):

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Fax to EDAC at 416-595-6399

\_\_\_\_\_  
Print Name and Credentials

\_\_\_\_\_  
Signature