Lifestyle Medicine Consultation Request

Referring Physician: _____ Date of Referral: _____

Patient Information:

Name _____

Address _____

Date of Birth _____

Contact Information: Phone Number _____
Email _____

Health Card (OHIP)_____

Primary Care Physician name and Contact information:
_____

Common Conditions we treat:

☐Cancer

☐ At Diagnosis
☐ Ongoing Treatment
☐ Post Cancer Treatment

☐ Chronic Pain
☐ Diabetes / Obesity
☐ Preparation for Surgery

Elective – Expected Procedure date_____
Procedure title _____

Urgent – Expected procedure date _____
Procedure title _____

☐ Other _____

Please contact us: T 647.343.4475 F 416.287.0992 www.centenarypainclinic.ca/

HYPERBARIC.CA ROUGE VALLEY HYPERBARIC MEDICAL CENTRE

DR. L Health Transformation Program
Treating and Preventing Chronic Diseases with Lifestyle Medicine-certified physicians

CENTENARY PAIN CLINIC