Edgar Psychological

Please complete all sections of this form and include a list of current medications.

Client's Information	
First Name	Last name
Personal Health Number (PHN)	DOB (dd-mm-yyyy)
Gender ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose	
Address:	
Primary Phone #	Secondary Phone #
Email Address:	

Clinical Information
Please include a list of current medications and consultation reports with this referral. This information will assist us to properly triage your patient. Please fax all documents to 780-757-7748. Once all documentation is received and reviewed, we will contact the client with further information
Diagnosis ☐ MDD ☐ PTSD ☐ cPTSD ☐ OCD ☐ Addiction ☐ Bipolar Affective Disorder ☐ Other
Reason for Referral or Diagnosis:
Other Specialists Involved in Care:

Relevant Past (Medical History):		
Height (cm):	Weight (kg):	
Blood Pressure:	HR:	BMI:

Referring Doctor Information	
Clinic:	Date:
First & Last Name:	PRACID #:
Address:	
Phone Number:	Fax Number:
Doctor's Signature	

Electronic signature disclaimer: By signing your name electronically on this referral form, you are agreeing that your electronic signature is the legal equivalent of your manual signature on this form.

Please fax all documents to 780-757-7748