Rebalance^{MD} Smoking Cessation Clinic

Rebalance MD

Phone 250 940 4444 Fax 250 385 9600

PATIENT INFORMATION: (affix label or complete)	REFERRING PHYSICIAN: (affix label or complete)
Name: PHN: DOB: Address: Home Phone: Alternate Phone: Email: Secondary Contact: WCB Claim # if applicable:	Name: MSP: Address: Phone: Fax: If applicable, Walk in Clinic Name: FAMILY PHYSICIAN: (if not referring MD)

DATE:

Letter Attached ❒

REASON FOR REFERRAL: Smoking Cessation Clinic

BOOKED FOR SURGERY: ❒ Yes, Surgical date: _____

Booked Procedure: _____

❒ No

Potential Procedure (if quit smoking): _____

MEDICAL & SURGICAL HISTORY: History attached ❒	MEDICATIONS: List Attached ❒
	ALLERGIES: List Attached ❒

Upon review, receipt of referral will be confirmed via fax to referring physician's office. An approximate wait for the appointment will be indicated. Patients will be contacted by surgeon's office to schedule appointment. Referring physicians will be advised by fax of appointment date once scheduled.

Version date: October, 2022