TRI HEALTH CLINIC

Sex & Couple's Therapy Ontario

www.trihealthclinic.com
admin@trihealthclinic.com
613-929-6518
613-900-1117
797 Princess St, Suite 414,
Kingston, ON, K7K 1G1

REFERRAL FORM

REFERRAL DATE: _____

PATIENT INFO

First Name	Last Name	Preferred Name

Date of Birth (Month, Day, Year)	Sex	Gender Identify	Sexual orientation (if known)

Primary phone number	☐ Yes ☐ No Permission to leave message?	Alternative phone number	☐ Yes ☐ No Permission to leave message?

Email address	☐ Yes ☐ No Permission to send email?

☐ Yes ☐ No Is patient aware that this referral is being made?	☐ Yes ☐ No Is patient aware that the Tri Health Clinic is a private clinic (*not* OHIP funded)?	☐ Yes ☐ No Has patient been provided with the Tri Health Clinic website (trihealthclinic.com)?

REFERRAL SOURCE

Name	Institution / Clinic / Address

Phone	Fax

REASON FOR REFERRAL

☐ Erectile dysfunction	☐ Delayed orgasm	☐ Early ejaculation	☐ Low sexual desire	☐ Genital/ pelvic pain	☐ Secondary to other health concerns	☐ Couples therapy	☐ Other
Select reason for referral							

Other reasons for referral	Relevant medications / medical history / social issues: