Elizabeth Parsons MD CCFP
admin@eparsonsmd.ca
Phone: 613-915-3621 **Please fax referral to:** 343-888-2011

Referral Form for group therapy

Date of referral: _____

Referring Clinician Information:

Name: **Billing #:**

Phone: **Fax:**

Patient Information:

Name: **OHIP w/ VC:**

DOB: **Email:**

Phone:

Reason for referral:

( ) Internal Family Systems therapy group.

( ) Mindful Self-compassion group

Additional notes on this patient (please include mental health history and list of medications):

Clinician's Signature: _____

***Please note that Dr. Parsons has a focused practice in psychotherapy so physicians in FHOs etc will not have billings negated.