



MEDICAN CLINIC BY ASPERIA



Mental Health Referral Form
Dr. Mahmoudi Shtewi- Adult and Peds ADHD Consults
MD, CCFP, CanReach Trained Physician

Client Information

Last Name: _____ First Name: _____

Date of Birth (day-month-year): _____ Gender: _____

Personal Health Number: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell Phone : _____ Email Address: _____

Legal Guardian Information

Last Name: _____ First Name : _____

Date of Birth (day- month-year) _____ Relation to the Patient : _____

Home Phone : _____ Cell Phone: _____ Email Address: _____

Please indicate any specific services you wish Dr. Shtewi to review

Paediatric ADHD

Adult ADHD (Dr. Shtewi conducts ADHD assessments exclusively for patients aged 40 and below)

Primary Adult/ Paediatric Mental Health Assessment

Medical Cannabis Treatment

Date of Referral: _____

Referring Physician

Name of Referring Physician: _____ Prac ID: _____

Phone: _____ Fax: _____

Clinic Address: _____

Family MD (if different from Referring Physician) : _____ Phone: 587-635-6216

Fax: 587-635-6211

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