PARSONS PARK MEDICAL CLINIC
Health For Life...

1087 Parsons Road SW
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SPECIALIST REFERRAL FORM

Date:

Patient Information- PHN:
First Name: *Last Name:*
DOB: *Gender:*
Address:
Phone Number:

General Psychiatry

☐ DR. SHAHNAWAZ KHAN

Referring Physician Name: _____ Prac ID: _____
Clinic Address: _____
Fax Number: _____ Phone Number: _____

Reason for referral:

Past medical history:

Current medication:

Has your patient been seen by a psychiatrist within the last year?
☐ YES ☐ NO
(If yes, please provide the consult notes)

Diagnosis, if known or suspected:

☐ ANXIETY DISORDER
☐ DEPRESSION
☐ BIPOLAR DISORDER
☐ OCD
☐ SCHIZOPHRENIA
☐ PTSD
☐ ADULT ADHD
☐ OTHER:_____

DOCTOR SIGNATURE: _____