threeOMs Yoga Therapy Referral Form

ALL INFORMATION GATHERED ON THIS FORM IS CONFIDENTIAL

PLEASE PRINT LEGIBLY AND FILL OUT ALL SECTIONS

SUBMIT VIA FAX (1-825-625-2500) ***OR PHONE*** (1-780-819-2511)

INFORMED CONSENT

***This referral has been discussed with my client/ patient?* YES NO

***My client/ patient is in agreement with the reason for this referral AND in agreement to working with a yoga therapist?* YES NO CONSULTATION

CLIENT/ PATIENT INFORMATION

Name: ______________________ DOB: ____________

Phone: ______________________ Email: ______________________

Address: ____

Reason for Referral: ______________________________________

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*** Please contact threeOMs Yoga Therapy to confirm if the referral is within scope of practice for yoga therapy, if uncertain.***

REFERRED BY

Name/ Professional Designation: ______________________________

Clinic/Business Name & Address: ______________________________

Phone: ______________________ Fax: ______________________

Email: ______________________ Date of Referral: ____________

*** I would like to receive regular updates on the client's yoga therapy direction of care?* *YES* *NO*

*** If YES, send updates via:* *FAX* *PHONE* *OTHER:* ______________________

How did you hear about threeOMs Yoga Therapy? ______________________

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Signature: ______________________ **OR**

Name of person filling out the form (if not named above): ______________________