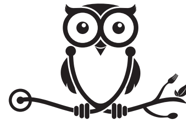


OWL POD

DREAM BIGGER

TELEMEDICE MENTAL HEALTH CLINIC

REFERRAL FORM

If patient is Indigenous, they will be seen within 2 weeks

- ☐ Status First Nation?
- ☐ 3rd Party Coverage?
- ☐ Patient has no coverage

Last, First Name: ______________________

PHN: ______________________

Email: ______________________

DOB: ______________________

Phone #: ______________________

Reason for referral

- ☐ Stress
- ☐ Weight management
- ☐ Depression
- ☐ Grief
- ☐ Anxiety
- ☐ Insomnia

Referring Physician

Name: ______________________

PRAC ID: ______________________

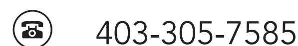
Phone #: ______________________

Fax #: ______________________

- Owl Pod does phone or video appointment only
- If your patient has bipolar disorder, psychotic or schizophrenia, we request that they are stable.
- We are not a crisis mental health service.

Contact us:

1 833 695 7637


403-305-7585

believe@owlpod.ca

You can send an e-consult request with **owlpod@therapysecure.com** or by AVA EMR.