

# LAYLA INTAKE REFERRAL FORM



Please fill out all relevant fields and fax this form to 647-277-1229. We will attempt to contact your patient within 24 business hours of receiving this form. Please note that your patient must provide us with consent to communicate with you in order for us to provide you with information on whether a match was made.

## Patient Information

Name (Last, First):

Date of Birth (DD/MM/YYYY):

Primary Telephone:

Patient consents to us leaving a voicemail:      Yes                      No

Email Address (optional):

Patient's preferred mode of contact (optional):      Email                      Phone

Patient has provided Referring Provider (named below) with consent to share their contact information and personal health information with Layla.

Patient consents to being contacted by Layla.

Please note that unless both of these boxes are checked, we are unable to contact this patient.

## Referring Provider Information

Name:    Fax:

Address:    Email (optional):

Telephone:    Signature:

## Referral Information

Reason for Referral:

Any Additional Comments:

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