

## **Adult ADHD Centre**

## www.parhar.com

BURNABY SQUARE
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**Medical Director** 

**Educational Director** 

Please complete this form

Fax: 604.525.8124

Email: ADHD@parhar.com

We will arrange to have the patient seen as soon as possible.



DATE:

PATIENT INFORMATION				
LAST NAME	FIRST N	FIRST NAME		
ADDRESS		CITY PROVINCE		ROVINCE
DOB (mm/dd/yy)	PHN#			
DOB (IIII/dd/yy)	11114#			
EMAIL ADDRESS	HOME	HOME PHONE CELLU		R PHONE
	( )	_	( )	_
ANY RELEVANT PATIENT INFORMATION				
(I.E. SYMPTOMS OR FUNCTIONAL PROBLEMS)				
REFERRAL SOURCE				
Physician/Nurse Practitioner:	FAX#		MSP#	