



**DR. G. PARHAR, MD   DR. A. PARHAR, BEd, MEd, PhD**

**Medical Director**

**Educational Director**

Please complete this form

**Fax: 604.525.8124**

**Email: [ADHD@parhar.com](mailto:ADHD@parhar.com)**

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



## PATIENT INFORMATION

LAST NAME		FIRST NAME	
ADDRESS		CITY	PROVINCE
DOB (mm/dd/yy)		PHN #	
EMAIL ADDRESS		HOME PHONE (   )   -	CELLULAR PHONE (   )   -

## ANY RELEVANT PATIENT INFORMATION (I.E. SYMPTOMS OR FUNCTIONAL PROBLEMS)

## REFERRAL SOURCE

Physician/Nurse Practitioner:	FAX #	MSP #
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DATE: \_\_\_\_\_