P.O. Box 47023, RPO 425
Toronto, Ontario M5B 2P9
Telephone: 416-367-3459 Fax: 416-367-4679

Standard Letter of Diagnosis

My patient, _____ D.O.B_____

Has been diagnosed with:_____

Symptoms include:_____

* I understand that my office will be contacted via phone to verify this information.

Patient Contact Information:

Address _____

_____

_____

Phone # _____ Email_____

To be completed by

M.D.___ R.N. (E.C)___ N.P. Doctor___ Chiropractor___

Medical Practitioner's Printed Name**:**_____Reg.#_____

Medical Practitioner's Signature:_____

Medical Practitioners Address:

_____

_____

_____

Phone #_____

Date signed:_____/_____/_____.
(Month) (Day) (Year)

Please keep a copy of this form at your doctor’s office
CALM reserves the right to refuse any member on a case by case basis