THEA Medical Clinic
8707 Dufferin St, Unit 26, Thornhill, ON, L4J 0A2
Tel: 416-480-6565 Fax: 647-493-3231

REFERRAL FORM

Patient Name: _____

Health Card No.: _____

Expiry Date: _____

Date of Birth: _____

Contact No: _____

Email: _____

Address: _____

PSYCHIATRY, PSYCHOTHERAPY, INTERNAL MEDICINE & GYNECOLOGY – Immediate Availability
Accepting New Referrals for In-Person and/or Virtual Appointments

THEA Medical Clinic is committed to delivering compassionate and evidence-based care to individuals experiencing. Our approach is centered on a profound respect and empathy for each person's unique journey. We firmly believe in the significance of fostering trusting therapeutic relationships and collaborating closely with our patients and their health care providers to devise personalized treatment plans tailored on their specific needs. We are dedicated to empowering our patients to achieve their optimal health and wellness.

Please circle a clinician below and/or check off the box for the next available ☐

Psychiatry (OHIP)

Dr. Jakov Raguz – Adult Psychiatrist

Dr. Dina Lagzdins – Adult Psychiatrist

Dr. Peter Wu – Adult Psychiatrist

Dr. Chijioke Ukwe – Adult Psychiatrist

Dr. Ahmed Mansour – Adult Psychiatrist

Dr. Mohammed Shokri Al-Masri – Adult Psychiatrist

Dr. Mohammed K. Khaleel – Adult/Geriatric Neuropsychiatrist

Dr. Attar M. Khan – Child/Adolescent/Adult Psychiatrist

Dr. Salman Wahid – Child Psychiatrist (ages 5-22)

Internal Medicine (OHIP)

Dr. Harris Joseph (he/him)

Dr. Melvin Philip (he/him)

Dr. Dalal Mazraeh (she/her)

GP-Psychotherapy (OHIP)

Dr. Jabiz Modaresi Esfeh (she/her)

Dr. Darryl Gebien (he/him)

Gyneocology

Dr. Yehuda Habaz (he/him)

Dr. Mandy Liedeman (she/her) – PAPS only

REASON FOR REFERRAL:

Provide as much information as possible for the reason of the referral in your referral letter:

(please note we unable to accept referrals for patients involved in legal proceedings)

- onset and/or duration of symptoms
- list of medications
- copies of any diagnostic tests, consults, and progress reports,
- diagnoses, if any
- medical conditions pertinent to the consult
- any other relevant information on the patient chart.

Name of Referring MD: _____ **OHIP Billing No:** _____

CPSO No: _____ **Date of Referral:** _____

Address: _____ **Phone:** _____ **Fax:** _____

Our office will contact the patient to book an appointment. • Please attach all relevant imaging, blood work and or consults.