



PHYSICIAN REFERRAL FORM

Please select Physician:

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Dr. Sharon Gurm, ND, FABNO

☐

Dr. Paulina Domzal, ND

Please select service

☐

Integrative oncology

☐

Clinical Nutrition or General IV

☐

Iron Infusion

☐

Women's / Men's Health

☐

Medical Aesthetics

☐

Long Covid/ Autoimmune conditions

☐

Peri/Menopause

☐

Prep for pregnancy

Patient Information

First Name: _____

Last Name: _____

PHN: _____

DOB: _____

PHONE: _____

EMAIL: _____

Patients will be called by Port Moody Health staff to arrange an appointment time

Please include the following to assist in setting the appointment at the earliest:

- Medical Records
- Diagnostic test results

Referring Physician Information

Clinic Name: _____

Physician Name: _____

Clinic Phone Number: _____

Fax Number: _____

Physician Signature: _____ Date: _____