Patient Referral Form

FULLMAST™
MEN'S HEALTH CLINICS

Patient name: _____ Referring doctor: _____

Address: _____ Billing #: _____

City: _____ Prov: _____ Postal Code: _____ Phone #: _____ E-mail: _____

Phone #: _____ E-mail: _____ Fax #: _____

Patient DOB: _____

OHIP #: _____

Reason for referral:

- ▢ Erectile dysfunction
  - Type (if diagnosed) ▢ Vasculogenic (▢ COVID symptom) ▢ Psychosocial ▢ Neurogenic
- ▢ Premature ejaculation
- ▢ Peyronie's (curved penis)
- ▢ Low testosterone

Other conditions:

- ▢ Cardiovascular disease
- ▢ Diabetes
- ▢ Prostatitis
- ▢ Prostatectomy: Date: _____ Details: _____

Active medications: _____

Other (history, major hospitalizations): _____

_____

Referring doctor's signature: _____ Date: _____

For appointment call: 1-844-500-1177 or email: book@fullmast.ca Fax: 647 689 2183