



Referral for Heuro™ (featuring PoNS™ Treatment) Program

**Once completed, please send this form to your chosen clinic offering Heuro™ services*

Date of Referral (DD/MM/YYYY): _____
Referring Canadian Physician Information
Canadian Physician Name: _____
Physician Licensing Number: _____
Phone Number (XXX-XXX-XXXX): _____
Fax Number (XXX-XXX-XXXX): _____
Patient Information
Patient Name: _____
Date of Birth (DD/MMM/YYYY): _____
Healthcare Number/PHN: _____
Phone Number (XXX-XXX-XXXX): _____
E-mail: _____
Reason for Referral (Issues, Condition, etc.): _____ _____ _____
Referring Physician Signature: _____
Signature Date (DD/MMM/YYYY): _____