

## Standard Letter of Diagnosis

My patient, \_\_\_\_\_ D.O.B. \_\_\_\_\_

has been diagnosed with: \_\_\_\_\_

symptoms include: \_\_\_\_\_

\*I understand that my office will be contacted by telephone to verify this information.

To be completed by  
**M.D. \_\_\_ N.P. Doctor \_\_\_ Chiropractor \_\_\_**

Practitioner's Name: \_\_\_\_\_ Reg.# \_\_\_\_\_

Practitioner's Signature: \_\_\_\_\_

### Medical Practitioner's Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone # \_\_\_\_\_

Date signed: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Month) (Day) (Year)

### Patient Contact Information: IMPORTANT

Address \_\_\_\_\_  
\_\_\_\_\_

Phone # \_\_\_\_\_ Email \_\_\_\_\_

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*

**Please complete and fax or send to:**  
**P.O. Box 47023, RPO 425**  
**Toronto, Ontario M5B 2P9**  
**Telephone: 416-367-3459 Fax: 416-367-4679**