FND PROGRAM
FUNCTIONAL NEUROLOGICAL DISORDERS PROGRAM SOCIETY

We are currently accepting referrals for our educational program. Treatment services are at capacity. Please check box to confirm that you are referring to our educational program. ☐

Patient name:	**Date of Referral:**	
DOB: (patient must be 18+)	**PHN:**	
Address:		
Phone:		
***Patient's email address:** **(This will be our main avenue of communication as well as allowing the patient access to the program's secure web platform)**		
GP/NP (if not referring doctor):	**Phone:**	**Fax:**
Referring doctor:	**Phone:**	**Fax:**
Physician confirming the diagnosis of FND: **(If referral is made by a physician not specializing in neurology/psychiatry/neuropsychiatry/gastroenterology/urology, this referral *must be* supported by a report produced by a specialist in one of these areas confirming the diagnosis of a Functional Neurological Disorder).**		
List of Medications: (Dosage/Frequency)		

Reason for referral (check all that apply)	
Functional Movement Disorder	
Non-Epileptic Attack Disorder	
Central Sensitization Syndrome-Functional Sensory Disorder	
Mild Neuro-Cognitive Disorder with functional or dissociative component	
Functional Urological Disorder	
Psychogenic Dysphagia-Functional Gastrointestinal Disorder	
Other conversion disorder	

Exclusion Criteria (check all that apply)		
Exclusion:	**Possible Alternative Service:**	
Factitious Disorder	Outpatient Psychological Services	
Chronic Pain Disorder	Regional Pain Program	
Narcotics-Related Sensory Disorders	Substance Use Disorders Service	
Requirement for other psychiatric treatment (depression/anxiety/schizophrenia)	Mental Health Services	
Major Neurocognitive Disorder	Older Adult Mental Health Services	

PLEASE NOTE: INCOMPLETE REFERRALS WILL BE RETURNED TO REFERRING DOCTOR

If you would like to receive this form electronically, please contact us.

21-21 Dallas Road, Victoria BC V8V 4Z9

Phone: 778-400-4248 Fax: 250-483-1503 Email: admin@fndprogram.ca