

## Patient Referral Form

Referring doctor: \_\_\_\_\_

Phone #: \_\_\_\_\_ E-mail: \_\_\_\_\_

Fax #: \_\_\_\_\_

Patient name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Prov: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

### Reason for referral:

- Erectile dysfunction  
Type (if diagnosed)  Vasculogenic  Psychosocial  Neurogenic
- Premature ejaculation
- Peyronie's
- Testosterone

### Related conditions:

- Cardiovascular disease
- Diabetes
  - Type 1  Type 2
- Prostatitis
- Urinary incontinence
- Prostatectomy: Date: \_\_\_\_\_ Details: \_\_\_\_\_

Notes:

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Referring doctor's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Patients can book an appointment by calling: 1-844-500-1177**

**or email: [book@fullmast.ca](mailto:book@fullmast.ca)**

**Fax: 647-689-2183**

FullMast, with four clinics in the GTA, treats erectile dysfunction using Dual-action SONICWAVE™ (LISTW). Clinics are located in Downtown Toronto, Oakville, Ajax and Brampton.