

PLEASE COMPLETE REFERRAL FORM AND FAX TO 780-757-2014

PATIENT INFORMATION

Personal Healthcare Number _____
Date of Birth (*month*) _____ (*day*) _____ (*year*) _____ Gender *M/F*
First Name _____ Middle Name _____
Last Name _____
Address _____
City _____ Province _____ Postal Code _____
Home Phone _____ Other Phone _____

SPECIALTY REQUIRED

- Cardiology
- Gynecology/Obstetrics
- Infectious Diseases
- Internal Medicine
- Nephrology
- Neurology
- Pediatrics
- Psychiatry
- Respirology
- Rheumatology
- Spine Triage Clinic (*Neurosurgery/Spine Surgery*)

REASON FOR REFERRAL

Referring Physician _____
Practitioner Identification Number _____
Referring Physician Telephone Number _____
Referring Physician Fax Number _____

Please attach recent blood work, diagnostic imaging results, and a list of current medications

WE THANK YOU FOR YOUR REFERRAL

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15313-97 Street
Edmonton, AB T5X 5V3
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