CLINIC REFERRAL FORM

1-367 St. Albert Trail, St. Albert, AB T8N 0R1
Phone: 780-569-5030

☐ **URGENT**

☐ **ROUTINE**

Please **COMPLETE REFERRAL FORM** and **FAX** to: 780-569-5031

Patient Name			
Phone Number:			
Address:			
City:	**Edmonton**	Province:	**AB**
Phone Number:			
Gender:	◯ **Male** ◯ **Female**		

Specialist Referral:

- ◯ Respirology
- ◯ Pediatrician
- ◯ Sleep Medicine
- ◯ Internal Medicine
- ◯ GP with dermatology training (no lipomas/no eye lesions)
- ◯ Gynecologist
- ◯ Urologist
- ◯ GP with special interest in mental health/weight management

REASON FOR THE REFERRAL:

REFERRING PHYSICIAN:

PRAC ID:

Phone: ( )

Fax: ( )