REFERRAL FORM

ENT Clinic

Dr. Peter McArthur, MD FRCS(C) FACS
Canadian Cancer Care
Edmonton Comprehensive Care & Family Medicine
110, 6925 Gateway Blvd NW
Edmonton, AB T6H 2J1
P: 780-306-5656 F: 780-306-5757

*FAX ONLY COMPLETED FORMS TO **780-306-5757**.*

PATIENT INFO	Name:		Gender: ☐Male ☐Female ☐Other
	Address:	City & Province:	Postal Code:
	Best Contact Phone Number:		
	Alberta Health Care:		Date of Birth:
REFERRING PHYSICAN INFO	Name:	Practitioner ID:	Specialty:
	Address:	City & Province:	Postal Code:
	Phone:	Fax:	Email:
FAMILY PHYSICIAN INFO	Name:		Practitioner ID:
	Address:	City & Province:	Postal Code:
	Phone:	Fax:	Email:

REFERRAL INFORAMTION	
REASON FOR REFERRAL	☐ general otolaryngology Other: ☐ laryngology ☐ otology / neurotology ☐ sleep/snoring
PATIENT MEDICAL HISTORY *If known: past medical history, surgical history, medications, allergies, family history, current medication*	

REFERRING MD SIGNATURE: _____DATE: _____