REFERRAL FORM

General Internal Medicine

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**.*

PROVIDING PHYSICIAN *Check one*	☐ Next available internist ☐ Dr. Jonathan Cena, PhD, MD, FRCP ☐ Dr. Harris Chou, MD, MSc, FRCPC ☐ Dr. Arjun Gupta, MD, FRCPC	☐ Dr. Lorie Kwong, MD, FRCPC ☐ Dr. Rahul Mehta, MD, FRCPC ☐ Dr. Maryam Rezaeeaval, MD, FRCPC ☐ Dr. Tarandeep Sandhu, MD, FRCPC	
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	☐ Hypertension ☐ Diabetes ☐ COPD ☐ Asthma ☐ Ischemic heart disease ☐ Congestive heart failure	☐ Dyslipidemia ☐ Benign hematology ☐ Preoperative assessments ☐ Venous thromboembolic disease ☐ Chronic kidney disease	☐ Hypothyroidism ☐ Hyperthyroidism ☐ Undifferentiated complex medical problems ☐ Other:
PATIENT MEDICAL HISTORY *If known: past medical history, surgical history, medications, allergies, family history, current medication*			

REFERRING MD SIGNATURE: ____ DATE: ____________________