REFERRAL FORM

ENT Clinic

☐ **DR. Peter McArthur, MD FRCS(C) FACS** ☐ **DR. JESSICA CLARK, MD, MSC, FRCSC**

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

REFERRING MD SIGNATURE: ____DATE: _____________________