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. Harris Chou, MD, MSc, FRCPC	☐ Dr. Lorie Kwong, MD, FRCPC ☐ Dr Emil Nath, BHSc, MD, FRCPC

	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	☐ Hypertensions ☐ Diabetes ☐ COPD ☐ Asthma ☐ Ischemic heart disease ☐ Congestive Heart Failure ☐ Dyslipidemia ☐ Benign hematology	☐ Per-operative 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: _____