REFERRAL FORM

ENT Clinic

€ DR. PETER MCARTHUR, MD FRCS(C) FACS € DR. AHMED DARWISH, MD, CCFP, FRCSI

€ DR. SHERIF IDRIS, MD, FRCS(C) MMCi

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Edmonton, AB T6H 2J1
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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 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: _____