



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 <i>Check one</i>	<ul style="list-style-type: none"> Next available Internist Dr Lazar Milovanovic, BSc, MD, FRCPC Dr Lesley Merkel, BScN, MD, FRCPC 		<ul style="list-style-type: none"> Dr. Lorie Kwong, MD, FRCPC 	
	Name:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
	Address:		City & Province:	Postal Code:
	Best Contact Phone Number:			
	Alberta Health Care:		Date of Birth:	
REFERRING PHYSICIAN 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 INFORMATION		
REASON FOR REFERRAL	<ul style="list-style-type: none"> Hypertensions Diabetes COPD Asthma Ischemic heart disease Congestive Heart Failure Dyslipidemia Benign hematology 	<ul style="list-style-type: none"> Per-operative assessments Venous thromboembolic disease Chronic kidney disease Hypothyroidism Hyperthyroidism Undifferentiated complex medical problems Other:
PATIENT MEDICAL HISTORY <i>If known: past medical history, surgical history, medications, allergies, family history, current medication</i>		

REFERRING MD SIGNATURE: _____ DATE: _____