Clearwater SPECIALIST CENTER

www.clearwaterspecialistcenter.ca

PLEASE COMPLETE REFERRAL FORM AND FAX TO 780-757-2014

PATIENT INFORMATION

Personal Healthcare Number____________________________________

Date of Birth (*month*) __________ (*day*) __________ (*year*) ________________ Gender *M/F*

First Name____________________________ Middle Name____________________________

Last Name____

Address____

City_________________________ Province________________ Postal Code_______________

Home Phone___________________________ Other Phone______________________________

SPECIALTY REQUIRED

- Cardiology
- Gynecology/Obstetrics
- General Surgery
- Neurology
- Pediatrics
- Rheumatology
- Spine Triage Clinic (*Neurosurgery/Spine Surgery*)

REASON FOR REFERRAL

Referring Physician____

Practitioner Identification Number____

Referring Physician Telephone Number____

Referring Physician Fax Number____

Please attach recent blood work, diagnostic imaging results, and a list of current medications

WE THANK YOU FOR YOUR REFERRAL

Clearwater Specialist Center
15353-97 Street NW
Edmonton, AB T5X 5V3
Phone (780) 757-2012 Fax (780) 757-2014