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______________________________ Email___________________________________
City_________________________ Province_______________ Postal Code_______________
Home Phone__________________________ Other Phone_____________________________

SPECIALTY REQUIRED

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

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