ENDOCRINE HEALTH CALGARY

Foothills Professional Building
Suite 248, 1620 29 St NW, Calgary, AB, T2N 4 L7
PH : (587) 392-4444, Fax :(403) 513-6063
Email : info@endocrinehealth.ca

DIABETES & ENDOCRINOLOGY REFERRAL FORM

Patient Appointment Information

Patient Name : ...First Name.../...Middle Name.../...Last Name...

Date of birth : ...YYYY...MM...DD... **PHN/ULI :** ..... ☐ **Female** ☐ **Male**

Address : .....

Postal code : .....**City :** .....**Province :** .....

PH : .....☐ **Work** .....☐ **Home**

ENDOCRINOLOGY SERVICES

- ☐ Diabetes
- ☐ Obesity
- ☐ Adrenal / Cortisol
- ☐ PTH / Calcium
- ☐ Lipid disorders
- ☐ Reproductive (male)
- ☐ Reproductive (female)
- ☐ Osteoporosis
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Thyroid(other)
- ☐ Hypertension
- ☐ Others

☐ **URGENT**

REASON FOR URGENCY

CLINICAL DETAILS

REFERRING PHYSICIAN INFORMATION

Physician name : ..... **Clinic name :** .....

Physician ID : ..... **Clinic address :** .....

Fax : ..... **Ph :** .....

Physician signature : ..... **Date of referral :** .....

NOTE :

- We will notify the patient and your office with appointment date and time.
- Patient will be provided with the lab requisition if there are tests to be completed before the appointment.
- We require 48 hour's notice to cancel or reschedule the appointment.
- Patient to attend 10 min before their appointment time.