



9136 – 23rd Ave NW, Edmonton, AB T6N1H9
Tel: 780-784-0920 Fax: 780-784-6689

Referral Form

Referring Physician

Name: PRACID:

Telephone: Fax:

Name and Location of Clinic: (if Doctor works out of multiple locations):

Patient Demographics

Patient's Name:

Gender: Date of Birth: Health Card #:

Address: City: Postal Code:

Home Phone: Cell Phone:

Patient Email address:

Urgency of Referral

Routine Urgent – please indicate why:

Reason for Consultation:

Nasal or sinus Rhinitis / Conjunctivitis Nasal polyps

Cough, Wheeze Asthma

Other breathing concerns:

Environmental allergy Food allergy Gut symptoms -? allergic

Skin – Eczema Hives / Urticaria Angioedema

Other skin problems:

Anaphylaxis Insect sting Penicillin

Other Drug (please specify):

COVID vaccine Latex Eosinophilia

Immunodeficiency

Other:



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Additional Information: