6720 – 104 Street NW
Edmonton, AB T6H 2L4
T: (780) 306-5555 | F: (780) 431-2554
welldiagnostics.ca

# DIABETES & ENDOCRINOLOGY CLINIC REFERRAL FORM

**PATIENT INFORMATION** (attach patient label)

Patient Name: ☐M ☐F
ULI: DOB:
Address: Postal Code:
City, Province: Home phone:
Email:

**REFERRING PHYSICIAN INFORMATION**

Physician Name: _____
Practice ID: _____
Clinic Name: _____
Clinic Address: _____
Ph: _____ Fax: _____

Relevant History:

☐ Urgent
Reason for Urgency:

Referring Physician Signature: _____
Date of Referral: _____

***Please Note:*** *We will fax the appointment date and time to your office and notify the patient by phone or letter. The patient may require labs to be completed prior to this appointment and a lab requisition will also be sent to the patient. We require 72-hour notice for cancellation or rescheduling of appointment.*

*For triage of referrals please select from the following:*

## GENERAL ENDOCRINOLOGY

- ☐ Adrenal
- ☐ Bariatric Matters / Obesity
- ☐ Calcium / Parathyroid
- ☐ Diabetes Management
- ☐ Dyslipidemia
- ☐ Hypertension
- ☐ Osteoporosis
- ☐ Pituitary
- ☐ Reproductive - Female
- ☐ Reproductive - Male
- ☐ Thyroid Disorder
- ☐ Other

## DIAGNOSTIC TESTING

- ☐ 24-hour ABPM
- ☐ 24-hour ABPM + Hypertension Consult

*NOW OFFERING 24-hour ABPM* – ***Booking within 1 week!***