#124, Meadowlark Health and Shopping Centre,156 Street & 87 Avenue
Edmonton, AB T5R5W9

Date of Referral:	
Patient Information Full Name: PHN: DOB: Sex Assigned at Birth: Gender:	Address: Home Phone Number: Cell Phone Number: Email:
Alternative Contact	
Full Name: Relationship:	Phone Number#:
Minor Referrals (Complete for patients less than 18)	
Parent/Guardian Name: Relationship:	Phone Number#: (if different than patient's)

Who has been informed of the referral?		
☐Patient	☐Guardian	☐Both

Referring Provider	
Name:	Clinic:

EWPCN Clinician (Complete if referral initiated by nursing or other primary care team member)
Name:
Preferred method of treatment collaboration (phone, email, etc.):

Additional Requirements

☐Patient has hearing requirements
☐Patient unable to communicate well in English
☐Interpreter Required; specify language:
☐Safety concerns (i.e. anger issues, irritability or impulsivity in interactions)

Referral for which Program(s) *Indicates attachment that is required for referral triage and booking.

☐Registered Dietitian *relevant specialist reports, growth chart required for minors;
☐Exercise Specialist *medical history
☐Psychiatry *referral letter
☐Behavioural Health Consultant
☐Social Work
☐Pharmacy
☐Low Risk Maternity Clinic
☐Contraception Counselling, IUD Insertion or Implanted Long-Acting Reversible Conception

Reasons for Referral (Must be Completed)

Incomplete Referral will be Returned

Fax to 780-481-9149