Lacombe Medical Clinic

GENERAL INTERNAL MEDICINE REFERRAL FORM

Hernando Leon MD, PhD, FRCPC, FACP

LACOMBE MEDICAL CLINIC
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PLEASE FILL OUT THE FOLLOWING REFERRAL FORM

Patient Name: _____ **DOB (M/D/Y):** _____ **PHH:** _____ **Gender: M F** **Address:** _____ _____ **Tel:** _____ **Alt. Tel:** _____ **Patient aware of referral** ☐ **Claim**	**Referral Source** (Physician only) **Name:** _____ **PRACID:** _____ **Address:** _____ _____ **Tel:** _____ **Fax:** _____ **Family MD:** _____

Reason for Referral (provide any supporting documentation)

Previous History & Investigations:	**Medications:**

Please indicate any specific services you wish MD to review:

- ☐ **Urgent Consultation**
- ☐ **Internal Medicine Consult**
- ☐ **Any additional comment**
- ☐ **Diagnosis & Treatment of problem**
- ☐ **Manage therapies & follow up care**

*** If the referring physician is using Connect Care and prefers that method for the referral, that method could be used as an option. Please ensure that is directed to Dr. Leon.**

PLEASE FAX REFERRAL TO 780 470-3379