ONE WELLNESS

HEALTH PRACTITIONER REFERRAL

FAX: 403-678-8898
Phone: 403-679-7179
177 Kananaskis Way, Canmore, AB T1W 0A3

Complete relevant fields and fax with supporting reports.

REFERRAL TO

☐ Dr. Triska — Regenerative Medicine & Musculoskeletal Care ☐ Dr. Connie Lebrun — Sports & Exercise Medicine

Requested service / clinical question (if known):

PATIENT INFORMATION

Full name *

Date of birth (YYYY-MM-DD) *

Phone *

Email

Address

Alberta Health Care Number * (required)

Preferred contact method

☐ Phone ☐ Email ☐ Either

REFERRING PRACTITIONER

Practitioner name / credentials *

Prac ID

Clinic / organization

Phone *

Fax

Email

Address

CLINICAL INFORMATION

Reason for referral / presenting concern *

Relevant history, examination findings, investigations and treatment to date

PRIORITY AND SUPPORTING INFORMATION

☐ Routine ☐ Urgent — please specify below **Urgency / timing details**

☐ Imaging / reports attached ☐ Lab results attached ☐ Clinical notes attached

I confirm this referral is made for patient care and the patient has been informed of the referral.

Referring practitioner signature

Date

Direct callback / best time