The Cleator Clinic

PHYSICIAN REFERRAL FORM

Patient Information

Name: _____

Address: _____

_____

Phone Numbers: Home: _____ Cellular: _____

Work: _____

Birthdate: _____

PHN: _____

Medical Coverage (MSP, RCMP, Private, Other): _____

Reason For Referral: _____

Allergies: _____

Medications: _____

Important Past History: _____

Urgency (Elective, Urgent, Semi-urgent): _____

Referring Physician

Name: _____

Billing number: _____

Location: _____

Phone Number: _____ Fax Number: _____

Clinic Appointment Booking Policy

We accept referrals by fax only: (604) 681-1517

The appointment time will be faxed to the referring physician's office when booked and they will inform the patient about their appointment time. There is a $75 charge for missed appointments / less than 24 hour cancellations. Further information is available at: ***www.haemorrhoids.ca***

This form must be completed and faxed by the referring physician's office only. Thank you.

Email: cleatorclinic@shawbiz.ca
Telephone: (604) 681-1513
Fax: (604) 681-1517

THE CLEATOR CLINIC
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Vancouver, BC V5Z 4E1