IMA Clinic (a division of C-health)
6720 – 104 Street NW
Edmonton, AB T6H 2L4
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www.c-health.ca

SAVE RESET PRINT

IMA CLINIC REFERRAL FORM

PATIENT INFORMATION (attach patient label)

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

REFERRING PHYSICIAN INFORMATION

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

Relevant History:

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.*

☐ Urgent
Reason for Urgency:

Referring Physician Signature:_____
Date of Referral: _____

For triage of referrals please select from the following:

GENERAL INTERNAL MEDICINE

- ☐ Hypertension
- ☐ Dyslipidemia
- ☐ Type 2 Diabetes
- ☐ Metabolic Syndrome
- ☐ Other:

IMA Clinic specialists have an interest in ***metabolic syndromes*** *and are accepting referrals for such at this time.*

We are proud to serve your patients' care needs!

IMA Clinic - A centre of excellence committed to delivering high quality specialist care in a timely manner!

C·health
Global best practices - Applied locally.