IMA Clinic (a division of C-health)
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# 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
- ☐ Cardiac Risk Assessment
- ☐ 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!***