

C-impact Clinic (a division of C-health)

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www.c-health.ca

C-IMPACT CLINIC REFERRAL FORM

PATIENT INFORMATION (attach patient label)	REFERRING PHYSICIAN INFORMATION
Patient Name: ULI: DOB: Address: Postal Code: City, Province: Home phone: Email:	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.
	For triage of referrals please select from the following: GENERAL INTERNAL MEDICINE Hypertension Dyslipidemia Type 2 Diabetes Metabolic Syndrome Cardiac Risk Assessment Thrombosis
☐ Urgent Reason for Urgency: Referring Physician Signature:	DIAGNOSTIC TESTING Diagnostic testing services via C-diagnostics (a division of C-health) □ 24-hour ABPM □ 24-hour ABPM + Hypertension Consult
	NOW OFFERING 24-hour ABPM – Booking within 1 week!
Date of Referral:	

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

