C·impact
Community-based Multi-specialty Care

C-impact Clinic (a division of C-health)
Suite 210, 1016 - 68 Avenue SW
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www.c-health.ca

C-IMPACT CLINIC REFERRAL FORM

PATIENT INFORMATION (attach patient label)

Patient Name: ☐M ☐F
ULI: DOB:
Address: Postal Code:
City, Province: Phone:
Email:

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
- ☐ Metabolic Syndrome
- ☐ Thrombosis
- ☐ Metabolic Associated Liver Disease
- ☐ Iron Deficiency Anemia
- ☐ Fatigue
- ☐ Other Internal Medicine Concern

Reason for referral must be clearly stated in relevant history

DIAGNOSTIC TESTING

Diagnostic testing services via C-diagnostics (a division of C-health)

- ☐ 24-hour ABPM
- ☐ 24-hour ABPM + Hypertension Consult

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