Centric Health
Orthopaedics
Your Care. Our Focus.

Calgary Orthopaedic Foot and Ankle Clinic

Patient Referral Form

Foot & Ankle Urgent Care Clinic

REFERRING PHYSICIAN INFORMATION:

NAME:

ADDRESS:

POSTAL CODE:

TEL#: _____

FAX#: _____

PRACID#: _____

PATIENT INFORMATION:

NAME: **M☐** **F☐**

ADDRESS:

POSTAL CODE:

TEL#: _____

AHC#: _____

Please provide best contact telephone number.

REASON FOR REFERRAL:

☐ Foot Sprain
☐ Foot Fracture
☐ Joint Injury
☐ Sports Injury
☐ Ankle Sprain
☐ Tendon Injury
☐ Achilles Tendon Injury
☐ Soft Tissue Injury

Imaging
☐ X-ray ☐ Bone Scan ☐ Ultrasound ☐ CT Scan ☐ MRI
Please have copy of report forwarded with the referral.

BRIEF HISTORY:

Physician Signature: _____

CLINIC USE ONLY

Referral Received: _____/_____/_____ **Appointment Scheduled: _____/_____/_____**
dd/mm/yy **dd/mm/yy**

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