Association of Alberta Podiatric Surgeons

www.albertaps.ca
association.ab.ps@gmail.com

Patient Referral Form

REFERRING PHYSICIAN INFORMATION:

NAME:

ADDRESS:

POSTAL CODE:

TEL#: _____

FAX#: _____

PRACID#: _____

PATIENT INFORMATION:

NAME: **M☐** **F☐**

ADDRESS:

POSTAL CODE:

TEL#: _____

AHC#: _____

REASON FOR REFERRAL:

☐ Diabetic Foot Evaluation
☐ Heal / Ankle Pain
☐ Sports Injury
☐ Surgical Consultation

Imaging Completed

☐ X-ray ☐ Bone Scan ☐ Ultrasound ☐ CT Scan ☐ MRI

BRIEF HISTORY:

_____

_____

_____

_____

Physician Signature: _____ **Date:** _____ **PRAC ID:** _____