



Referring Physician: _____

PRAC ID: _____

Phone: _____ Fax: _____

Patient Name: _____

Date of Birth (DOB): _____ PHN: _____

Phone: _____ Address: _____

Referral To:

- Dr. Asem Werdi (Internal Medicine)**
- Dr.Suneet Johal (Internal Medicine/ Geriatric)**
- First Available**

Our Internal Medicine Specialists are available to provide consultations in the following areas

- | | | | | | |
|------------------|--------------------------|------------|--------------------------|---------------------------|--------------------------|
| Cardiology | <input type="checkbox"/> | Nephrology | <input type="checkbox"/> | Respiratory / Pulmonology | <input type="checkbox"/> |
| Endocrinology | <input type="checkbox"/> | Hematology | <input type="checkbox"/> | Neurology | <input type="checkbox"/> |
| Gastroenterology | <input type="checkbox"/> | Geriatrics | <input type="checkbox"/> | | |

Reason for Referral (check all that apply):

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Syncope / Dizziness | <input type="checkbox"/> Dyspepsia / GERD |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Abnormal ECG or Holter | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> IBS / IBD |
| <input type="checkbox"/> Proteinuria / Hematuria | <input type="checkbox"/> Electrolyte Abnormalities | <input type="checkbox"/> Diabetes (Type 1 / Type 2) | <input type="checkbox"/> Chronic Diarrhea |
| <input type="checkbox"/> Thyroid Disorders | <input type="checkbox"/> Adrenal/Pituitary Disorders | <input type="checkbox"/> Obesity | <input type="checkbox"/> Abnormal Imaging (Liver/GI) |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Iron Overload | <input type="checkbox"/> Weight Loss/Gain |
| <input type="checkbox"/> Thrombocytopenia | <input type="checkbox"/> Leukocytosis | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Lymphadenopathy | <input type="checkbox"/> Elevated LFTs |

Other (please specify): _____

Clinical Information / Reason for Consultation:

Referring Physician Signature: _____ **Date:** _____

Preferred Contact for Booking (if applicable): _____

Asperia Medical Clinic
7471 101 Ave NW Edmonton T6A3Z5
Fax : 587 557 4466
Phone 587 557 4455

MediCan Clinic By Asperia
7115 101 Ave NW Edmonton T6A 0H9
Fax : 587 635 6211
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