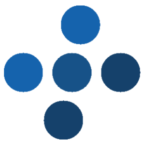

WELL Health
Hemorrhoid Treatment Centres

www.wellhealthhtc.com
#207 8120 Beddington Blvd
Calgary, AB T3K 2A8

Physician Referral Form

Patient's Name Last Name/First Name		**Referring Physician**	
Patient's Address or Stamp		**Physicians Address or Stamp**	
Health Card No		**Physician Referring No**	
DOB dd/mm/yyyy	**Phone No**	**Physician's Phone No**	**Physicians Fax No**

Reason for Referral/Presenting Issues:

☐ Hemorrhoids

☐ Rectal Bleeding

☐ Rectal Pain

☐ Anal Fissure

☐ Other (please specify)____

Medical History:

☐ On anticoagulants

☐ ASA or Plavix

*****Please include most recent colonoscopy and/or FIT results if applicable*****

Referring Physician Signature:

FAX REFERRAL TO: 825-206-1011

infoAlberta@wellhealthhtc.com
T: 825-206-1010
F: 825-206-1011