WELL Health
Hemorrhoid Treatment Centres

www.weallhealthhtc.com
T: 604-951-0159
F: 604-951-1807

Physician Referral Form

Date of Referral	**Patient Details**
Date of Referral_____ yyyy/mm/dd	Name:
	Health Card:
	DOB:
	Phone:
	Email:
	Address:

Please Confirm Preferred Location:

☐ Vancouver ☐ Surrey

Reason for Referral/Presenting Issues:

☐ Hemorrhoids

☐ Rectal Bleeding

☐ Rectal Pain

☐ Anal Fissure

☐ Other (please specify)_____

Has the patient had a Colonoscopy within last 5 years? Yes ☐ No ☐

Has the patient had a Fecal Occult Blood Test within last 5 years? Yes ☐ No ☐

Please fax us the following information:

☐ Completed referral form

☐ Most recent Colonoscopy (if applicable)

☐ Most recent FOBT result

☐ Past medical history

Referred by:

Physician_____ Billing #_____

Address_____ Phone #_____

FAX REFERRAL TO: 604-951-1807

#37 15300 105 Ave
Surrey BC
V3R 6A7

#1407 750 W Broadway
Vancouver BC
V5Z 1H2