UNITED
Cardio Lab

United Health Centres
#103 7609 109 St NW Edmonton AB T6G 1C3

Please send all referrals via fax to **780 761 9110**.

REFERRAL FORM

Patient Last Name: Patient First Name:

PHN/ULI: DOB (dd/mm/yyyy):

Address:

Contact Number: Gender:

Email:

REFERRING PHYSICIAN INFORMATION

Physician Last Name: Physician First Name:

Address:

Phone: Fax:

REFER TO

- ☐ ECG
- ☐ Echo

REASON FOR REFERRAL:

Signature: _____ **DATE:** _____

Phone: 780-761-9111
Fax: 780-761-9110
Email: appointments@unitedhealthcentres.com
Website: www.unitedhealthcentres.com