



AĒSTHETIX MD

QUALITAS CARE CLINIC
COSMETIC · MEDICAL · WELLNESS

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REFERRAL FORM · OBSTETRICS & GYNECOLOGY

Dr. Safa Elhassan

MBBS, MRCOG · Speaks English and Arabic

FAX COMPLETED FORM TO

587-689-3184

01 PATIENT INFORMATION

Full name _____ Date of birth (YYYY / MM / DD) _____ / _____ / _____

Phone _____ Alberta Health Care # _____

Address _____

City _____ Province _____ Postal code _____

02 REASON FOR REFERRAL

Reason for referral

Clinical question / desired outcome

03 SYMPTOMS, HISTORY & INVESTIGATIONS

Relevant symptoms / history

e.g. menstrual issues, pain, bleeding, fertility, menopausal concerns

Investigations completed

☐ Pap test

☐ Ultrasound

☐ Labs (specify) _____

☐ Other (specify) _____

Pertinent medical / surgical history

04 REFERRAL TYPE & URGENCY

Referral type

☐ Gynecology (general)

☐ Menopause care

☐ Prenatal & maternity care

☐ Contraception & family planning

☐ Well-woman exam & Pap test

☐ Fertility consult

☐ Menstrual & pelvic concerns

☐ Other _____

Urgency

☐ Routine – within 4-8 weeks

☐ Semi-urgent – within 2-4 weeks

☐ Urgent – within 1-2 weeks

☐ ASAP – please also call

Reason for urgency

05 SUPPORTING DOCUMENTS ATTACHED

☐ Patient summary / referral letter ☐ Lab results ☐ Ultrasound / imaging ☐ Pap results ☐ Other _____

06 REFERRING PHYSICIAN / CLINIC

Name _____

Billing / Prac ID # _____

Clinic / practice _____

Phone _____

Signature _____

Fax _____

Date (YYYY / MM / DD) _____ / _____ / _____

THANK YOU FOR YOUR REFERRAL