Cardio 1

Endocrinology Referral

Provider Name: _____
Family Physician: Yes? ☐ No? ☐
Clinic / Hospital: _____
Address: _____
_____
Phone: _____
Fax: _____
Date: _____

Patient Information:

Name: _____
PHN: _____ MHSC# _____ ☐ Male
DOB: (dd/mmm/yy) _____ ☐ Female
Address: _____ ☐ Other _____
City: _____ Province: _____
Postal code: _____ Email: _____
Home phone # _____
Cell: _____
Work: _____
Languages Spoken: _____

☐ Outpatient ☐ Inpatient – site: _____

Step 1: Select Endocrinologist: ☐ Dr. Eyal Kraut

Step 2: Please include the following with a consult letter:

- **List of Medications**
- **Most Recent Lab Results**
- **Imaging Results**

****Please refer all patients under the age of 16 to a pediatric endocrinologist at HSC****

Referrals will be triaged by Cardio 1 staff. For prompt booking, please ensure all sections are fully completed.

Signature: Date:

Cardio 1
2-230 Osborne Street, Winnipeg, MB, R3L1Z5
Ph: 204-287-5222 Fax: 204-287-5223