# Integria
PRECISION MEDICINE

# Referral Form

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www.integriaprecisionmedicine.com

## Patient Information (or place patient label here)

First Name: Last Name:

DOB: DD-MM-YYYY PHN:

Phone #: Email:

Gender: ☐ Female ☐ Male ☐ Other:

Height: Weight: BMI:

Family Physician/Nurse Practitioner:

## Referring Provider Information

MD/NP Name:

Practitioner ID #:

Phone: Fax:

MD/NP Signature:

Requested timeline:

☐ Routine/Non-urgent ☐ Urgent ( ⩽2 weeks)

## Indication(s) for Referral

| Cardiovascular | Endocrine | Metabolic | Hematologic |
|---|---|---|---|
| ☐ Hypertension | ☐ Perimenopause | ☐ Pre-diabetes | ☐ Anemia |
| ☐ Orthostatic BP | ☐ Menopause | ☐ Diabetes | ☐ Polycythemia |
| ☐ Angina/chest pain | ☐ Low bone density | ☐ Dyslipidemia | ☐ Iron deficiency |
| ☐ Heart failure | ☐ Osteoporosis | ☐ Weight management | ☐ Elevated Ferritin |
| ☐ Atrial fibrillation | ☐ Low testosterone | ☐ Hypothyroidism | ☐ Abnormal CBC |
| ☐ CV risk assessment | ☐ Adrenal disorder | ☐ Hyperthyroidism | ☐ Abnormal INR/PTT |

☐ Other (please explain):

## Referral Request Information (Fill out below **or** attach H&P, medications & relevant investigations to this referral)

Reason for referral:

Clinical Question(s) to be answered:

Patient's Medical Profile:

Medication(s):

Allergies:

**Please fax completed referral & accompanying documents to:**
**1 (855) 685-4554**