Alberta Health Services

Gamma Knife Referral

Last Name	
First Name	Middle Name
PHN#	Birthdate *(yyyy-Mon-dd)*

Fax completed form to: **780-407-1199** or

Mail to: University of Alberta Hospital - 1C2.64 WMC
8440 112 St NW, Edmonton, AB, T6G 2B7

If you have questions or require assistance, call 780-407-8278

☐ Routine ☐ **Urgent** *(Treatment required within 10 business days)*	**Date of Referral** *(yyyy-Mon-dd)*
Reason for urgency	

Additional Patient Information

Address	City	Prov	Postal Code
Phone	Alt Phone	Email	

Does the patient have a legal guardian?
☐ No ☐ Yes *(If yes, complete information below)* ▼

Guardian Name	Relationship	Phone

Patient Diagnosis

Reason for Referral

Is patient aware of this referral? ☐ No ☐ Yes

Referral Requirements *(If not available on Alberta Netcare, enclose pathology and imaging reports, clinical notes and other relevant information)*

☐ Pathology Reports enclosed
☐ Imaging Reports enclosed *(also send DVD or CD images if imaging was not performed in Alberta)*
☐ Other enclosed *(specify)* _____

Patient Factors Affecting Care

☐ Language *(specify)* _____ Interpreter required ☐ No ☐ Yes

Physical limitations *(describe)*

Social/Psychological *(describe)*

Other Notes

Primary Care Provider Name	Phone	Fax

Is Primary Care Provider the referring physician? ☐ No *(If no, complete information below)* ▼ ☐ Yes

Referring Physician Name	Phone	Fax

Referring Physician's Signature