Alberta Health Services

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN
MRN	
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X)	

Calgary Voice Program Referral

Complete this referral for services to the Calgary Voice Program. The Calgary Voice Program provides tertiary level, interdisciplinary assessment and management of adults with laryngeal and upper-airway disorders.

Referrals are only accepted from Specialist Physician.

Note - Referring Physican consult notes **must** accompany the referral.

Submit referrals by **fax** to 403.476.9638. For inquiries **call** 403.955.8377.

The Program triages referrals and contacts patients directly regarding appointments.

Referral Information		
Reason for Referral		
Type of Request ☐ Routine ☐ Urgent *(List reason(s) for urgency)* _____ _____		
Medications		
Smoking History		
Please list other relevant documentation(s) attached		
First Name of Family Physician	Last Name of Family Physician	Phone Number
Name of Referring Physician	Signature	Date *(dd-Mon-yyyy)*
Specialty/Professional Designation	Phone Number	Fax Number