24-Hour Blood Pressure Monitoring Referral Form

Primary Care Network
CALGARY WEST CENTRAL

Fax to the location of your choice using the specific fax number in the left-hand column below.

Locations

Calgary southwest

☐ **Core Pharmacy & Travel Clinic**
201-722 85th St. S.W.
P: 403.454.2333
F: 403.454.9466

☐ **C-Health**
Rockyview Health Centre II,
210-1016 68th Ave. S.W.
P: 403.541.0033
F: 403.541.0032

Calgary northwest

☐ **Advanced Respiratory Network**
250-8730 Country Hills Blvd. N.W.
P: 403.873.0891
F: 403.735.5163

Calgary northeast

☐ **Advanced Cardiology**
201-3151 27th St. N.E.
P: 403.235.4109
F: 403.235.4147

Calgary southeast

☐ **Advanced Cardiology**
250-8500 Blackfoot Tr. S.E.
P: 403.879.7911
F: 403.879.7899

☐ **Advanced Respiratory Network**
Sunpark Professional Centre
225-40 Sunpark Plz. S.E.
P: 403.873.0891
F: 403.873.1817

Please note: There is no fee for this service.

Date of referral: _____ **Current blood pressure:** _____

Required for all referrals: Please specify **reason(s) for the referral** in the space below and **attach any relevant information**.

Patient information *Affix patient label or enter information here*

Patient name: _____ PHN: _____ DOB (yyyyy/mm/dd): _____

Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose ☐ Other: _____

Address (include city and postal code): _____

Phone: (H): _____ (C): _____

Pronouns: ☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other: _____

Physician information

Referring physician name: _____

Clinic name: _____

Clinic address (include city and postal code): _____

Clinic phone: _____ Clinic fax: _____

Family physician name (if different): _____

Additional report to: _____

Physician signature: _____

Service provider use only *Record attempts to contact patient*

☐ Referring doctor has been advised of outcome

ADVANCED CARDIOLOGY | ADVANCED RESPIRATORY CARE NETWORK Respiratory, Sleep and Cardiac Service | CORE PHARMACY & TRAVEL CLINIC | C-diagnostics Cardiometabolic Cardiopulmonary Testing