Valiant™ CLINIC

The future of healthcare, today.

Consultation / Referral Form

Referring physician: _____ Title: _____
Date: _____ Tel: _____ Email: _____

Patient name: _____ DOB: _____
Male ☐ Female ☐ Telephone: _____

Reason(s) for referral:

_____

_____

Type of Referral:

Consultation

- ☐ Cardiology
- ☐ Dentistry
- ☐ Dermatology
- ☐ Dietetics
- ☐ Endocrinology
- ☐ ENT
- ☐ Family Medicine
- ☐ Gastroenterology
- ☐ Genetic Counselling
- ☐ Life Coaching
- ☐ Obstetrics and Gynecology
- ☐ Ophthalmology
- ☐ Orthopedics and Sports Medicine
- ☐ Pediatrics
- ☐ Physiotherapy
- ☐ Psychology
- ☐ Pulmonology
- ☐ Urology

Procedure (please specify)

- ☐ Cardiology:
  - ○ **Stress Test**
  - ○ **Echocardiogram**
  - ○ **Stress Echo**
- ☐ Dental Hygiene _____
- ☐ Dermatology _____
- ☐ Endoscopy _____
- ☐ Pulmonary Function/Bronchoscopy _____
- ☐ Urology _____
- ☐ Other _____

Short Medical History:

_____

_____

Referrer's Signature: _____ **Stamp:** _____