HART FAMILY MEDICAL
AND IUD CLINIC

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Circumcision Referral Form

I am referring:

Patient Name:	Date of birth:
AHC #:	Primary parent name:
Address:	Parent phone #:

Referring MD:	
PracID:	
Phone #:	Fax #:

Patient's Medical History

Medical conditions: _____

Baby's current weight: _____ When was weight taken?_____

Was child premature? ☐
If yes, what is corrected age (equal to full term)? _____

We will contact your patient directly within 7 days for booking a circumcision. Babies 1-3 months are booked directly to procedure. After the procedure is done, the referring physician will be provided with a consult letter. Thank you for your kind referral!

Please fax completed form to: (403) 452 - 7311