EFry Health Centre

9683 137th Street
Surrey, BC, V3T 4G8
info@EFryHealth.ca
EFryHealth.ca

Primary Care and Dental Referral Program

Central Intake
Email referral to: referral@efryhealth.ca

Date: _____/_____/_____
Day / Month / Year

Name: _____
First Middle Last

Personal Health Number: _____

Birth Date: _____/_____/_____
Day / Month / Year

CLIENT DETAILS

Gender (Circle one): Male Female Transgender Other: _____

Preferred Pronoun (Circle one): She-Her He-Him They-Them

Permanent Address: _____ **City:** _____

Postal Code: _____ **Phone:** _____

Referring Organization/Provider

Program Information	Person Submitting Referral
Title: _____	**Title:** _____
Location: _____	**Name:** _____
Phone: _____	**Phone:** _____
Fax: _____	**Fax:** _____
	Email: _____

REFERRAL INFORMATION

Reason for Referral:

_____ _____
Name **Signature**

Please email the referral to: referrals@efryhealth.ca

Thank you for referring your client to the EFry Health Centre Team!