# STI Referral Form

**Phone:** (780) 705 - 8400 ext. 2
**Fax:** +1 (855) 710 - 7863

**Patient Name:** ______________________ **Referral Date:** ____________

**PHN:** ____________ **Phone #:** ____________ **Alternate #** ____________

**DOB:** ____________ **Address:** ______________________

## Reason for Referral

◯ **HIV Testing** ◯ **HIV Prep** ◯ **STI Clinic**

**Name of Referring Dr.** ______________________ **Prac ID:** ____________

**Name of Clinic:** ______________________

**Phone #:** ____________ **Fax #:** ____________

**Physician Signature:** ____________