PHYSICIAN REFERRAL FORM

Instructions for Referring Providers:

- This form is for healthcare providers requesting a formal Physician Consultation for patients with suspected Hypermobility.
- If criteria are met, patients will receive additional questionnaires directly from Hypermobility Canada.
- **Please note** that additional exclusions may apply. Hypermobility Canada operates within a defined scope of practice, and referrals may be declined if they fall outside this scope or if we determine that the consultation is unlikely to be beneficial for the patient.

PATIENT INFORMATION		
Legal Last Name:	Legal First Name:	Middle Name:
Provincial Health Number:	Date of Birth (DD-MON-YYYY):	Preferred Pronouns:
Sex Assigned at Birth: ☐ Male ☐ Female ☐ Other	Gender Identity: ☐ Woman ☐ Man ☐ Non-Binary ☐ Two-Spirit ☐ Other:_____ ☐ Prefer not to say	
Full Address:		
City:	Province:	Postal Code:
Primary Phone Number:	Secondary Phone:	Email:
IF PEDIATRIC PATIENT (<18 YEARS)		
Primary Parent/Guardian Full Name:	Relationship:	
Phone:	Email:	

REFERRING PROVIDER INFORMATION	
Referring Provider Full Name:	AB PRAC ID:
Other Referral ID (Non-Alberta):	Province of (Non-Alberta) Provider:
Referring Provider Clinic Name:	Phone Number:
Address:	Fax Number:
*Please indicate the following: ☐ Patient is aware of the referral and agrees to be contacted by Hypermobility Calgary.	

HYPERMOBILITY CANADA

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REASON FOR CONSULTATION: (Select all that apply)
☐ Diagnostic review/examination for hypermobility syndrome (e.g., hEDS, kyphoscoliotic EDS) ☐ Diagnostic assessment of POTS (Postural Orthostatic Tachycardia Syndrome) ☐ Diagnostic assessment of MCAS (Mast Cell Activation Syndrome) ☐ Genetic testing interpretation (attach previous reports) ○ Labs accepted: Blueprint Genetics, Invitae, Prevention Genetics, GeneDx, Alberta Precision Laboratories, Discovery DNA ○ Note: Publicly funded genetic testing guidelines must be met. Out-of-Country special tests are not arranged.
Specific Reason/Clinical Question:

Core Assessment Components:

1. Medical History:

Please list any relevant comorbidities:

Hypermobility History (Subluxations, dislocations, affected areas):

Previous hypermobility diagnosis or label: _____

2. Physical Examination

Beighton Score (attach detailed scoring per joint): _____

Other relevant hypermobility features:

_____

3. Medications:

Current Medication Names:	Dosages:	Intolerances/Adverse Reactions:

What medications worked/ did not work?

4. Previous Management Suggestions/Recommendations:

List prior treatments/interventions:	Outcome:

Current Management Plan:

Attachments:

- ☐ Previous genetic test reports
- ☐ Lab results
- ☐ Relevant imaging
- ☐ Other supporting documentation

Referring Provider Signature: _____ Date: _____

Please email a copy of the completed referral form to: info@hypermobilitycanada.com