

**Instructions for Referring Providers:**

- This form is for healthcare providers requesting a formal Physician Consultation for patients with suspected Hypermobility. Please complete all fields on this form.
- Please complete this form electronically. If you are handwriting any information, please ensure you **print clearly**.
- 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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Gender Identity: <input type="checkbox"/> Woman <input type="checkbox"/> Other: _____ <input type="checkbox"/> Man <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Non-Binary	
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: <input type="checkbox"/> Patient is aware of the referral and agrees to be contacted by Hypermobility Calgary.	

REASON FOR CONSULTATION: (Select all that apply)		
<input type="checkbox"/> Diagnostic review/examination for hypermobility syndrome (e.g., hEDS, kyphoscoliotic EDS) <input type="checkbox"/> Diagnostic assessment of POTS (Postural Orthostatic Tachycardia Syndrome) <input type="checkbox"/> Diagnostic assessment of MCAS (Mast Cell Activation Syndrome) <input type="checkbox"/> Genetic testing interpretation (attach previous reports) <ul style="list-style-type: none"> <li>○ Labs accepted: Blueprint Genetics, Invitae, Prevention Genetics, GeneDx, Alberta Precision Laboratories, Discovery DNA</li> <li>○ Note: Publicly funded genetic testing guidelines must be met. Out-of-Country special tests are not arranged.</li> </ul>		
Specific Reason/Clinical Question:		
Core Assessment Components:		
1. Medical History:		
Please list any relevant comorbidities:		
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Hypermobility History (Subluxations, dislocations, affected areas):		
<hr/> <hr/> <hr/> <hr/>		
Previous hypermobility diagnosis or label: _____		
2. Physical Examination		
Beighton Score (attach detailed scoring per joint): _____		
*If you are not sure how to complete a Beighton Score assessment please refer to our referral page for further instructions.		
Other relevant hypermobility features:		
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3. Medications:		
Current Medication Names:	Dosages:	Intolerances/Adverse Reactions:


What medications worked/ did not work?

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**4. Previous Management Suggestions/Recommendations:**

List prior treatments/interventions:	Outcome:

Current Management Plan:

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**Attachments:**

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

**Referring Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please fax a copy of the completed referral form and any supporting documents to: 833-527-9507**