

Connect Care Referral

Type directly into the form. Where indicated, required referral information may be attached. Ensure referral meets specific referral requirements where these are available. For more information on criteria and where to send the referral visit: www.albertareferraldirectory.ca

Last Name	First Name
Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First	
PHN/ULI	DOB (dd-Mon-yyyy)
Administrative Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary/Prefer not to disclose (x) <input type="checkbox"/> Unknown	

Date (dd/Mon/yyyy)	Refer to: Calgary COPD & Asthma Program		Fax: 403-476-7772
Patient Address			Phone
Referring Provider/Source			Phone
Referring Provider Address			Fax
Family Physician			
Legal Guardian Name	Phone	Relationship	
Referral Information			
Reason for referral			
Priority of referral	<input type="checkbox"/> Routine	<input type="checkbox"/> Urgent	
Type of referral	<input type="checkbox"/> Consultation	<input type="checkbox"/> e-Consult	
Patient's Current Status	<input type="checkbox"/> Stable	<input type="checkbox"/> Worsening	<input type="checkbox"/> See Comments <input type="checkbox"/> See Attached Letter
Comments			
Current and Past Management			
Is this referral for a new problem? <input type="checkbox"/> Yes <input type="checkbox"/> No If No , Date Previously Referred (dd/Mon/yyyy)			
If No - who were they previously referred to		If No , Diagnosis/Outcome of previous referral	
<input type="checkbox"/> Currently hospitalized, where?			
Relevant hospital admission (past 2 years) <input type="checkbox"/> Yes (If yes, when and where?) <input type="checkbox"/> No			
Past Medical History		<input type="checkbox"/> Attached	
Current Medications/Allergies		<input type="checkbox"/> Attached	
Processing Requirements (Check if included)			
<input type="checkbox"/> Blood work		<input type="checkbox"/> Diagnostic imaging	<input type="checkbox"/> Consultant letters
<input type="checkbox"/> Discharge summaries		<input type="checkbox"/> Microbiology	<input type="checkbox"/> Pathology
Patient Request for Consideration			
Physician		Location	
Factors that may affect Consultation/Care			
<input type="checkbox"/> Physical limitations		<input type="checkbox"/> Social/Psychological	<input type="checkbox"/> Economic <input type="checkbox"/> Other
Details			
Interpreter required <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, what language?)			
Completed By			
Name	Signature	Designation	Date (dd/Mon/yyyy)