Alberta Health Services

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 ☐ Last ☐ First	
PHN/ULI	DOB *(dd-Mon-yyyy)*
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X) ☐ Unknown	

Date *(dd/Mon/yyyy)*	Refer to: **Teen Asthma Program, Rockyview Hospital** Fax: 403-592-4201	
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	☐ Routine	☐ Urgent		
Type of referral	☐ Consultation	☐ e-Consult		
Patient's Current Status	☐ Stable	☐ Worsening	☐ See Comments	☐ See Attached Letter

Comments

Current and Past Management

Is this referral for a new problem? ☐ Yes ☐ No **If No**, Date Previously Referred *(dd/Mon/yyyy)*

If No - who were they previously referred to	**If No**, Diagnosis/Outcome of previous referral

☐ Currently hospitalized, where?

Relevant hospital admission *(past 2 years)* ☐ Yes *(If yes, when and where?)* ☐ No

Past Medical History ☐ Attached

Current Medications/Allergies ☐ Attached

Processing Requirements ***(Check if included)***

☐ Blood work	☐ Diagnostic imaging	☐ Consultant letters
☐ Discharge summaries	☐ Microbiology	☐ Pathology

Patient Request for Consideration

Physician	Location

Factors that may affect Consultation/Care

☐ Physical limitations ☐ Social/Psychological ☐ Economic ☐ Other

Details

Interpreter required ☐ No ☐ Yes *(If yes, what language?)*

Completed By

Name	Signature	Designation	Date *(dd/Mon/yyyy)*