Alberta Health Services

HRN: Site: DOB: yyyy/mon/dd

Last Name: First and Additional Names:

PHN: Gender: Age in Years:
Admitting Physician: Encounter #:

Address: Street, City, Province, Postal Code

Telephone Number:
Date of Admission: yyyy/mon/dd Family Physician:

Generic Referral

Please type directly into the form. Where indicated, required referral information may be attached. Please ensure referral meets specific referral requirements where these are available.

Date *(yyyy-Mon-dd)*	Refer to	Fax
Referring provider/source		Phone
Address		Fax
Family Physician		
Guardian/Appointed Agent *(if applicable)*		
Patient Guardian Name	Phone	Relationship

Referral Information

Reason for referral

Type of referral
☐ New referral ☐ Re-referral ☐ 2nd opinion ☐ Urgent referral
☐ Service/consultant is aware of urgent referral
Reason for urgency _____

Specialist seen previously ☐ No ☐ Yes ▼

If ***Yes*** Date seen	If ***Yes*** Diagnosis	Diagnosis Date *(yyyy-Mon-dd)*

Prior hospital admission *(past 2 years)* ☐ No ☐ Yes *(If yes, when and where?)* _____
☐ Currently hospitalized, where? _____

Past Medical History ☐ Attached

Current Medications/Allergies ☐ Attached

Requested Action

☐ Confirm and/or advise diagnosis ☐ Assume future management of patient within area of expertise
☐ Confirm and/or advise management, including medication ☐ Telephone consultation
☐ Assume management for this problem and return patient after care ☐ Patient education

Processing Requirements *(Check if included)*

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

Factors that may affect consultation/care

Specific patient request
☐ Physician _____ ☐ Location _____
Language _____ ☐ Interpreter required
Physical limitations _____
Social/Psychological _____
Economic _____ Other _____

For office use only

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