Alberta Health Services

Affix patient label within this box.

Integrated Home Care Physician Referral

Fax Referrals to Community Care Access – 403.943.1602

Physician/Source Details	
Referring Physician/Source	Phone Number
Address	Fax Number
Family/Primary Physician	Is Family Physician aware of referral? ☐ Yes ☐ No

Patient Information		
Last Name	First Name	Date of Birth *(yyyy-Mon-dd)*
Alberta Personal Health Number	Gender: ☐ Male ☐ Female	
Address		
City/Town	Province	Postal Code
Home Phone	Work Phone	Other

Does client have a legal guardian? ☐ Yes ☐ No Name _____ Phone _____

Reason for Referral – attach any pertinent physician's orders

Urgency of Referral: ☐ Same Day ☐ Within 24 hours ☐ Within 3 Days ☐ Within 7 Days ☐ Within 8–14 Days

Diagnosis and Date (if known)	*(yyyy-Mon-dd)*
1.	
2.	
3.	
4.	
5.	

Aware of Diagnosis: ☐ Client ☐ Family

Allergies

Current Medications

Past Medical History

Prior Hospital Admissions (past 2 years) – Site(s)

Factors that may affect care in the community (if known)

☐ Language spoken _____ ☐ Interpreter required _____

☐ Physical limitations _____ ☐ Psychological _____

☐ Economic _____ ☐ Other _____

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