Alberta Health Services

# Community Care Access Referral

All fields in **bold** must be completed along with any other applicable fields.
Once competed **fax** to 403.943.1602

**Last Name**

**First Name** | Middle Initials

**Personal Health Number**

**Date of Birth** *(yyyy-Mon-dd)* | Age

**Permanent Address** ☐ Location of initial visit

*(Street)*

*(City)* *(Postal Code)*

**Home Phone** | Work Phone

**Current Address** ☐ Same as above
☐ Location of initial visit

*(Street)*

*(City)* *(Postal Code)*

Home Phone | Work Phone

**Rural Tax District**

**Gender** ☐ Male ☐ Female

Marital Status
☐ Single ☐ Married ☐ Common-law
☐ Separated ☐ Divorced ☐ Widowed

**Language**
1st _____ 2nd _____

Interpreter Required ☐ No ☐ Yes Available ☐ No ☐ Yes

Name of Interpreter _____
Interpreter Phone _____

**Residence Type** *(circle number)*

**1** Private Home, Condo, Apartment
**2** Lodge
**3** Personal Care Home
**4** Private Assisted Living
**5** Long Term Care
**6** Group Home
**7** Hotel/Motel
**8** Shelter
**9** Other *(specify)* _____

**Living Arrangements** *(circle number)*

**1** alone **4** with others
**2** with spouse **5** group setting
**3** with child

## Referral Information

**Date Referral Initiated** *(yyyy-Mon-dd)*

Date Admitted to Acute Care *(yyyy-Mon-dd)*

**Discharge from Acute Care** *(yyyy-Mon-dd)*

**Acute Care Site** | Acute Care Unit #

**Referred by** *(i.e. Physician office, self)*

Phone

## Current Active Diagnoses

1)

2)

3)

Aware of Diagnoses
☐ Client
☐ Family

Aware of HC Referral
☐ Client
☐ Family

**Name of Community Care Physician** *(last, first)*

Fax | Phone

Other Physician *(last, first)* | Other Physician Phone

**Caregiver / Contact Primary Caregiver** ☐ No ☐ Yes

*(last, first name)*

Relationship to client

Phone *(home)* _____
*(work)* _____
*(cell)* _____

## *For Transition Services Use Only*

**Date of Initial Visit** *(yyyy-Mon-dd)*

PARIS ID #

Community

HC Team *(i.e. SC, SN)*

Alberta Health Services

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**Name** *(last, first)*

## Reason for Referral

## History / Presenting Problem

| Date *(yyyy-Mon-dd)* | Weight *(kg)* | Blood Pressure | Heart Rate | Temp | Resp |
|---|---|---|---|---|---|
| | | | | | |

Caregiver Coping ☐ N/A ☐ Yes ☐ No *(specify)* _____

## Safety of Client *(check all that apply)*

☐ None ☐ Not Known

☐ **Allergies** *(specify)* _____

☐ Fall risk _____

☐ Home environment _____

☐ Smoking in the home _____

☐ Altered cognition *(specify)* _____

☐ Lack of equipment in home *(specify)* _____

☐ Power Dependent ☐ No ☐ Yes

☐ Other _____

## Infectious Disease History

☐ None ☐ Not Known

☐ C Difficile ☐ ARO ☐ HIV+

☐ Hepatitis ☐ TB

☐ Other *(specify)* _____

☐ Uncontrolled drainage/diarrhea *(specify)* _____

☐ URI _____

## Safety of Staff *(check all that apply)*

☐ No Identified Risk

☐ Pet(s) *(specify)* _____

☐ Known active substance abuse *(check and specify those that apply)*

- ☐ Alcohol _____
- ☐ Narcotics _____
- ☐ Street drugs _____
- ☐ Other _____

☐ Behavioural concerns of client *(specify)* _____

☐ Behavioural concerns of others *(specify)* _____

☐ Other safety concerns *(e.g. weapons)* _____

| **Name of Others Currently Involved in Care** | **Phone** |
|---|---|
| | |
| **Name of Ambulatory Clinic / Program** | **Phone** |
| | |

Alberta Health Services

# Community Care Access Referral

**Name** *(last, first)*

## Professional Services and Support Required

☐ Assessment for Supportive Care
☐ Chronic Disease Management
☐ Edema Management
☐ Environment Assessment for Caregiver Safety
☐ Medication Management
☐ Pain/Symptom Management
☐ Respiratory Care
☐ Wound Care

☐ Exercise Program
☐ Pain Management (with Modalities)
☐ Extremity Edema Management / Lower Leg Assessment
☐ Gait / Balance
☐ Respiratory Rehabilitation
☐ Walking Aids / Mobility

☐ Assess Support Surface
☐ Cognitive Retraining
☐ Energy Conservation
☐ Environmental Adaptation
☐ Feeding / Swallowing
☐ Safety in Home
☐ Small ADL Equipment
☐ Large ADL Equipment (e.g. lifts)
☐ Other _____

## Services that require Physician Orders

| | |
|---|---|
| ☐ Acute Ortho Follow-up | ☐ Orders attached |
| ☐ Catheter Change/Care | ☐ Orders attached |
| ☐ Home Parenteral Therapy | ☐ Orders attached |
| ☐ Injections | ☐ Orders attached |
| ☐ Parenteral Nutrition (TPN) | ☐ Orders attached |
| ☐ Peritoneal Dialysis (CAPD) | ☐ Orders attached |

## Advance Care Planning

☐ Personal Directive
☐ No ☐ Yes

☐ Goals of Care
☐ No ☐ Yes

## Referral Information Completed by

**Name** *(last, first)*

**Discipline** *(RN, SW, OT, PT, Other)*

**Signature**

**Date** *(yyyy-Mon-dd)*

**Department / Program / Agency**

Is there a need for Home Care staff to contact you directly?

☐ No ☐ Yes – Phone _____ Pager _____