Alberta Health Services

Community Accessible Rehabilitation (CAR) Neuro Referral

Phone 403.943.0279
Fax the completed form to 403.943.0578

Incomplete or unreadable referrals will be returned

Last Name	First Name
PHN / HRN	
Address	
Phone	Date of Birth *(yyyy-Mon-dd)*

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

Referral Information

Diagnosis	Date of diagnosis / injury / event
Surgery and date *(yyyy-Mon-dd)*	Length of hospital stay
	Date of discharge

Co-morbid conditions that may impact rehabilitation ☐ Not applicable
☐ Mental health condition ☐ Progressive cognitive decline *(i.e. dementia)* ☐ Alcohol / drug use
☐ Learning disorder ☐ Seizures ☐ Other ____________________

Relevant past medical history, precautions

Funding source(s) available ☐ Section B ☐ WCB ☐ Other insurance

Client's current living situation ☐ Alone ☐ With others ☐ Homeless ☐ Long term care
☐ Personal care home ☐ Designated Assisted Living ☐ Other ____________________
☐ Concerns with living situation ____________________

Reason for Referral *(please check off goals below)*

Please specify client's **active** rehabilitation goal(s) in the area(s) of
☐ Cognition
☐ Communication
☐ Community or household management
☐ Functional mobility
☐ Psychosocial
☐ Recreation
☐ Return-to-work or school / Productivity
☐ Splinting / Orthoses, specify:
☐ Upper extremity treatment
☐ Vision / Perception
☐ Visual-Vestibular
☐ Other ____________________
____

Please check to confirm that
☐ Client is currently able to participate in active ambulatory rehab program
☐ Client is aware of this referral

Client's current rate of recovery / progress
☐ Weekly
☐ If not weekly, please describe
____
____

Vocational status
☐ Client was working / @ school at time of injury / event
☐ Client currently working / @ school
☐ Client likely to return to work / school within 3 months
☐ Client likely to return to work / school in 3–12 months

Rehabilitation Received to Date *(please describe – including duration)*

☐ Client is currently receiving rehabilitation. (*Specify location / program)* ____________________
☐ Client has been provided with a home program *(please attach)*

Other referrals made or pending *(e.g. neuropsychology assessment)*

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Documents required to process this referral *(if on SCM, please indicate document topics and dates)*

☐ Medical discharge report, ______________________________

☐ Recent therapy progress notes / discharge report, ______________________________

Referral Source **Name**	Professional designation	Referring agency / clinic / facility
Fax	Phone	Email
Specialist *(i.e. physiatrist, neurologist)* Name	Date of next visit	
Fax	Phone	Email
Family Physician	Name	
Fax	Phone	Email

Booking Information

Preferred CAR site / location

Central	North	South
☐ Sheldon M. Chumir Health Centre 1213 4th Street SW	☐ Peter Lougheed Centre 3500 26 Avenue NE3	☐ South Calgary Health Centre 1 Sunpark Plaza SE

☐ No preference
☐ Client understands that they must arrange their own transportation to CAR appointments

☐ Language or communication barrier,
* Requires interpreter, Language ______________________________
* Communication barrier ______________________________

☐ Client will attend appointments with a support person

Alternate contact for booking appointments *(if applicable)*	Name	
Phone	Email	Relationship