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:

Alberta Health Services

Community Accessible Rehabilitation Referral

Central Coordination | Fax - 403.943.0578 | Phone - 403.943.0279

☐ **South: Calgary Health Centre** 31 Sunpark Plaza SE

☐ **Central: Sheldon M. Chumir Centre** 1213 4th Street SW

☐ **North: Peter Lougheed Centre** 3500 26 Avenue NE

All of the sections below must be completed in order to process the referral.

Location at Time of Referral *(unit, home, etc)*

Is client aware that referral has been made?
☐ Yes ☐ No

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

Contact to Book Appointment *(name/phone)*
☐ Client ☐ Other ____________________

Diagnosis and Date of Onset / Injury:

Please Attach: ☐ MRI/CT Reports ☐ Rehab Assessments Completed
☐ Recent Investigations/Consultation Reports ☐ Discharge Summary

Surgery and Date *(if applicable)*

Relevant Past Medical History and Precautions

Check if Applicable: ☐ Dementia ☐ Developmental Disability ☐ Mental Health Diagnosis

Functional Concerns / Limitations / Goals:

Current Living Situation upon Discharge *(please check)*
☐ Home ☐ Alone ☐ Long Term Care ☐ Personal Care Home ☐ Designated Assisted Living
☐ With Others ____________________ ☐ Temporary situation ☐ Permanent situation
List of concerns: ____________________

Funding Source *(please check)*
☐ Alberta Health Care ☐ WCB ☐ Other *(specify)* ____________________

Current Services in Place *(please check)*
☐ Home Care ☐ Living Well ☐ Private Therapy
☐ Day Hospital ☐ CNS ☐ Other ____________________

Needs an interpreter
☐ No
☐ Yes, Language ____________________

Family Physician
Phone ____________________
Fax ____________________

Specialist / Surgeon
Phone ____________________
Fax ____________________

Referral Source Name *(please print clearly)*
____

Professional Designation of Referral Source:
☐ Dr. ☐ PT ☐ OT ☐ SLP
☐ Other ____________________

Referral Source *(location/agency)*
____
Phone ____________________ Fax ____________________
Email ____________________

Request for Discharge Summary from CAR ☐ Yes ☐ No

Request for Telehealth ☐ Yes ☐ No

Upcoming Appointments Booked *(e.g. BI Clinic)*
☐ No ☐ Yes, Date *(yyyy-Mon-dd)* ____________________ Name of Physician ____________________