



## Community Accessible Rehabilitation Referral

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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> <b>South: Calgary Health Centre</b><br>31 Sunpark Plaza SE<br>Phone: 403-943-9484<br>Fax: 403-943-9485 | <input type="checkbox"/> <b>North: Peter Lougheed Centre</b><br>3500 26 Avenue NE<br>Phone: 403-943-4786<br>Fax: 403-943-4520 | <input type="checkbox"/> <b>Central: Sheldon M. Chumir Centre</b><br>1213 4th Street SW<br>Phone: 403-955-6900<br>Fax: 403-955-6910 |
|---|---|---|

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: \_\_\_\_\_

Site		
Date of Referral (yyyy-Mon-dd)		
Diagnosis and Date of Onset / Injury		
Surgery and Date		
Relevant Past Medical History and Precautions		
Check if applicable <input type="checkbox"/> Dementia <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Mental Health Diagnosis		
Treatment / Rehabilitation Goals		
<b>Current Living Situation</b> (please check) <input type="checkbox"/> Home <input type="checkbox"/> Personal Care Home <input type="checkbox"/> Designated Assisted Living <input type="checkbox"/> Long Term Care		
<b>Funding Source</b> (please check) <input type="checkbox"/> Alberta Health Care <input type="checkbox"/> WCB <input type="checkbox"/> Other (specify) _____		
<b>Current Services in Place</b> (please check) <input type="checkbox"/> Home Care <input type="checkbox"/> Living Well <input type="checkbox"/> Private Therapy <input type="checkbox"/> Day Hospital <input type="checkbox"/> CNS <input type="checkbox"/> Other _____		
Physician / Surgeon / Psychiatrist		
<b>Needs an interpreter</b> <input type="checkbox"/> Yes, language _____ <input type="checkbox"/> No		
<b>Telehealth Requested</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
Referral Source Signature	Referral Source Contact Phone	Referral Source Contact Fax
<b>Referral Source Designation</b> <input type="checkbox"/> Dr. <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> Other _____		<b>Request for Discharge Summary</b> <input type="checkbox"/> Yes <input type="checkbox"/> No