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

Community Care Access Referral

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 _____