Alberta Health Services

Generic Referral

Ensure referral meets specific referral requirements where these are available. For more information on criteria and where to send the referral visit: www.albertareferraldirectory.ca

This referral form could also be completed electronically within the Telus Health and Accuro EMRs using the "*QuRE Consultation-Referral Request and Response*" template.

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB*(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X)		

Date *(dd/Mon/yyyy)*	Refer to

Patient Address	Phone
Referring Provider/Source	Phone
Referring Provider Address	Fax
Family Physician	

Legal Guardian Name	Phone	Relationship

Who has been informed of the reason for this referral?   ☐ Patient   ☐ Guardian   ☐ Patient and Guardian

Additional Patient Information   ☐ Patient has guardian   ☐ Patient has alternative contact
☐ Patient unable to communicate well in English   ☐ Patient has vision requirements
☐ Patient has hearing requirements   ☐ WCB claim

Special Considerations   ☐ Interpreter required   ☐ Physical limitations
☐ Social / Psychological   ☐ Economic   Details: _____

Referral Information

Reason for referral

Type of Request	☐ Advice	☐ Consult	
Priority of Referral	☐ Routine	☐ Urgent	☐ Emergent
Patient's Current Status	☐ Stable	☐ Worsening	

Patient Expectation

Findings and/or investigations

Current and Past Management

Medical History

Active Medications

Allergies

Surgical History

Family History

Information given to patient

Completed By

Name	Signature	Designation	Date *(dd/Mon/yyyy)*

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