Alberta Health Services

Student/Health Care Worker Immunization Referral

Date *(dd-Mon-yyyy)*	Last Name	First Name
Date of Birth *(dd-Mon-yyyy)*		Personal Health Number
Address		
City	Province	Postal Code
Home Phone Number _____ Voice Mail? ☐ Yes ☐ No *(having voicemail ensures easier contact)*		Cell Phone Number _____ Voice Mail? ☐ Yes ☐ No
Email Address		
Family Physician Name *(first, last)*		Physician Address
Name of School/Employer		
Program/Occupation		Start Date *(dd-Mon-yyyy)*
Country of Birth	Immunization Records attached? ☐ Yes ☐ No	
History of Chickenpox (varicella) Disease? ☐ Yes ☐ No ☐ Unknown		

Office Use Only

Date Referral Received *(dd-Mon-yyyy)*		Records ☐ Yes ☐ No	
Sero Email Sent	Endemic	Non-Endemic	Note
Sero Received Ref in Que	Email Sent		

Alberta Health Services collects this health information as authorized by Section 20(b) of the Health Information Act (HIA). This information is used to provide health services [s27(1)(a)], determine eligibility for health services [s27(1)(b)], or for other uses authorized by the HIA (such as planning or quality improvement).
Information may be provided to your family physician where further follow up is required. Information will not be disclosed to your school or employer without your consent. If you have any questions about this, please contact the public health office at the phone number provided to you.