Alberta Health Services

Patient label placed here (if applicable) or if labels are not used, minimum information below is required.	
Last Name	First Name
Birthdate *(yyyy-Mon-dd)*	Gender
PHN / ULI	

North Zone Continuing Care Access Referral

Seniors Health
Phone 1.855.371.4122
Fax 1.855.776.3805

Discharge Date *(yyyy-Mon-dd)*

Service Required Within ☐ 24 hours ☐ 48 hours ☐ 72 hours ☐ 7 days

Client/Family Aware of Referral ☐ Yes ☐ No

Client Information

Street or Rural Address

City	Postal Code	Ph 1	Ph 2

☐ Third Party Billing
☐ WCB Claim *(specify number)* ______________________

Family Physician

Alternate Contact ***(If client unavailable or requires assistance with intake)***

Last Name	First Name	
Relationship to Client	Ph 1	Ph 2

Health Services Required

Relevant Health Conditions/Current Health Issues

☐ PT/OT *(specify)*

☐ AADL *(specify)*

☐ Equipment Only *(specify)*

Home Care ☐ Able to Attend Home Care Clinic

Type of Home Care Professional Service Required *(check all that apply)*

☐ wound care *(specify in Notes)* ☐ placement ☐ assessment/education *(specify in Notes)*
☐ personal care ☐ palliative ☐ other *(specify)* ___________________________

Notes

Attach All Relevant Documents ***(check all that apply)***

☐ **Demographics Sheet** ☐ **Discharge Instructions**
☐ **Physician Orders** ☐ **Medication Reconciliation**

Referral Source ***(please print)***

Completed by	Designation	Phone

20350 (2017-02)