Alberta Health Services

Community Accessible Rehabilitation (CAR) Musculoskeletal / Upper Extremity Referral

Name *(last first)*	
PHN / HRN	
Address	
Gender ☐ Female ☐ Male	Date of Birth *(yyyy-Mon-dd)*

Central Coordination: **Fax** - 403.943.0578 **Phone** - 403.943.0279

Central:	**North:**	**South:**
Sheldon M. Chumir Centre	**Peter Lougheed Centre**	**South Calgary Health Centre**
1213 4th Street SW	3500 26 Avenue NE	31 Sunpark Plaza SE

Incomplete or unreadable referrals will be returned for clarification.

Date of Referral *(yyyy-Mon-dd)* Client aware referral has been made ☐	Best Contact to Book Appointment ☐ Client Phone _____ ☐ Other _____ Phone _____

Diagnosis / Injury / Related Surgeries. Please include dates.

Attached / SCM date _____

☐ Recent investigations / consultation reports
☐ Recent therapy progress / discharge reports

Treatment Requested

Precautions and Contra-indications

Relevant Past Medical History

Check *(if applicable)* ☐ Neurological condition _____ ☐ Mental health condition _____

Funding Source *(please check)*

☐ Alberta Health Care ☐ Motor Vehicle Insurance
☐ WCB ☐ Other *(specify)* _____

Needs an Interpreter

☐ No ☐ Yes – Language _____

Referral Source Name *(please print clearly)*	Phone	Fax
Professional Designation of Referral Source ☐ Dr. ☐ OT ☐ PT ☐ Other _____	Email	
Specialist *(if different from referral source)*	Phone	Fax
Follow-up appointment with Specialist – Date *(yyyy-Mon-dd)*		