Alberta Health Services

Musculoskeletal - Rheumatology Referral
Community Accessible Rehabilitation (CAR)

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)*	Best Contact to Book Appointment
Client aware referral has been made ☐	☐ Client Phone _____
	☐ Other _____ Phone _____

Diagnosis / Injury / Related Surgeries. Please include dates.

Attached / SCM date _____

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

☐ Client has attended / is scheduled to attend Exercise, Joint Protection and Energy Conservation Class at RRDTC prior to referral to CAR.

Treatment Requested

☐ Splinting _____
☐ Activities of daily living techniques / adaptive devices
☐ Joint protection and energy conservation techniques
☐ AS Class
☐ Core stability / posture
☐ Stretching / flexibility
☐ Balance / proprioception
☐ Strengthening
☐ Other _____

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)*		