



Place Label on box below

Last Name	First Name
Birthday (yyyy-Mon-dd)	
Gender	
PHN #	

South Zone - Home Care Referral

If the Client is a resident of South Zone and is aware and agreeable to the referral, continue with the form, if not **STOP** do **not** refer.

Exclusion Criteria

1. No Personal Health Number (PHN) in Alberta and is **NOT** applying for one.
2. If WCB call 1-866-922-9221
3. Resides on Indigenous Reserves - Refer to Reserve Home Care Services
4. Routine Post C-Section suture removal - Refer to Public Health

Send completed Fax to - East - 403-529-8027 ▶ For questions call - 1-844-529-8084
West - 403-388-6577 ▶ For questions call - 1-866-388-6380

Demographics		
Service Address (Where care will be provided)		Phone
Mailing <input type="checkbox"/> (Same as above)		
Primary Contact Person & Relationship		Primary Contact Phone
Reason For Referral		
<input type="checkbox"/> Home Care Assessment <input type="checkbox"/> Palliative <input type="checkbox"/> Respite Care <input type="checkbox"/> Living Options Assessment <input type="checkbox"/> PICC dressing <input type="checkbox"/> Wound Care <input type="checkbox"/> Equipment <input type="checkbox"/> Lower Leg Assessment <input type="checkbox"/> Other _____		
Pertinent Diagnosis/Relevant History/Comments		
Is the client able to attend appointments in the Home Care Community Clinic? (IV, wound, assess lower leg) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Physician Orders (Medication Orders, Wound Protocol, Suture Removal, Catheter Orders, PICC insertion record, etc.)		
Attach Outpatient Treatment Record/Hospital Notes		
Physician Name (Last, First)		Signature (Required for all physician orders)
		Date (dd/Mon/yyyy)
Date of Discharge (dd/Mon/yyyy)		Surgical Procedure and Procedure Date (dd/Mon/yyyy)
Referring Source		
Completed By (First Name, Last Name)		Hospital Unit/ Clinic
		Phone
Family Physician (if different than above), (First Name, Last Name)		
Coordinated Access Centre Use Only		
Referral Processed <input type="checkbox"/> Yes <input type="checkbox"/> No, if no why? _____		Date (dd/Mon/yyyy)