Primary Care Alberta

Request InformAlberta (IA) and/or Alberta Referral Directory (ARD) Service Listing

Use this form to request an IA and/or ARD service listing. Complete all sections and submit to healthlink@primarycarealberta.ca and ard@primarycarealberta.ca and it will be determined if your listing will be published in one or both directories based on service criteria.
Content may be edited to comply with IA and ARD data standards. If your service is offered at multiple locations, a separate form must be completed for each location. For AHS only: The service description and some contact information will be maintained in InformAlberta.ca and referral details will be maintained in the ARD.
If you have questions or need support, please contact us.

Who Is Responsible for This Service Listing		
Main Service Contact Full Name *(The contact responsible for reviewing and maintaining IA and ARD profile content.)*		
Email Address	Role	Phone Number
Service Manager or Secondary Contact Full Name		
Email Address	Phone Number	

For InformAlberta (IA) Service Record Only
Complete the Service Information sections to create an InformAlberta record.
If submitting a combined IA and ARD request, complete both service and referral sections of the form.

Service Information

Service Name *(Indicate the official service or clinic name)*

Alternate Service Names
(Keywords your service is known by, including acronyms, former names, to help improve users search results.)

Organization Name

☐ Provinical ☐ Zone ☐ Other, *Specify* _____

Affiliation/ Partners *(Non-AHS)*

Short Description
Provide a brief description that summarizes the services offered *(1 or 2 sentences)*.

Full Description
Intended to help patients and referring providers determine if the service meets their care needs.
Helpful information to include are services offered or how to access the service. Omit detailing clinical problems in this section.

Primary Care Alberta

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Service Information Continued

Key Providers
List the types of providers who deliver this service *(e.g., social workers, registered nurses, doctors, health inspectors, etc.)*

Interpreter/ Translation Services
Does this service offer translation services?
☐ No, If not AHS, specify languages offered _____
☐ Yes

Is a fee reduction offered?
☐ No
☐ Yes, provide details

Location Name *(Name of physical address, building name, hospital, street name etc.)*

Service Address
Is the Address confidential? ☐ No ☐ Yes

Building/ Facility Name

Suite/ Room Number	Street Address	
City	Province	Postal Code

Is there wheelchair access?
☐ No ☐ Yes
Notes

Mailing Address *(Complete only if different than service address)*

Phone Number *(Include at least one location specific phone number to support wayfinding)*	**Phone Name or Notes** *Example. Scheduled Appointments Only*

Additional Phone Number	**Phone Name or Notes**
☐ General Line ☐ Referral Line	
☐ General Line ☐ Referral Line	

Fax Number	**Fax Name or Notes**
☐ General Line ☐ Referral Line	
☐ General Line ☐ Referral Line	

Toll Free Phone number	TTY

Primary Care Alberta

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Service Information Continued

Hours of Operation

Specify when clients are able to access this service to book an appointment or call for more information.
(ex. Parking services are offered 24 hours at the hospitals, the parking office is open from 8-4 Monday to Friday.
The Parking Office hours are listed as Service Hours.)

☐ 24/7 ☐ Closed on statutory

Operation Day(s) and Hours of Operation	**Notes** *(hours of other services, program times, lunch hour, etc.)*
Monday hours _____	
Tuesday hours _____	
Wednesday hours_____	
Thursday hours_____	
Friday hours_____	
Saturday hours_____	
Sunday hours_____	

Specialty *(ex. Neurology, Pediatrics, Family Medicine, etc.)*

Eligbility Requirements / Criteria

Describe the service's inclusion and exclusion criteria for a patient to be accepted

- Particular groups accepted or not accepted such as out-of-province, age restrictions, or other important characteristics
- Services completed prior to a referral being submitted *(e.g., needs to be seen by a Neurologist first)*

If your service accepts referrals or procedural orders in Connect Care, please indicate order type, department name, ID, and referral pool triage.

☐ Not applicable to my service

Connect Care Department Name_____
(ex. EDMONTON ZONE GI CAT)

Connect Care Department Name_____
(ex. 102220)

Referral Pool Triage_____
(ex. EDMONTON ZONE GI CAT REFERRAL TRIAGE)

Primary Care Alberta

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For Alberta Referral Directory (ARD) Service Update Only

Referral Information

How are the referral(s) accepted?

☐ Written Communication
☐ Referral Form
Form links for AHS services only
☐ Connect Care Referral Form
☐ Generic Referral

Clinic Specific Forms

Include your services clinic forms for a patient to be accepted *(referral form, registration form, online booking, assessment form, etc.)* Add the form name and web address link *(URL).*Word or PDF documents are not accepted.

Form Name	URL

Process for Non-Connect Care User ☐ **Not applicable to my service**

Instructions for primary care, community care, private providers etc. who do not send referrals via Connect Care.
(ex. Complete the referral form and fax it to the service using the contact information in this profile.)

Select the mode of referral submission

☐ Phone ☐ Fax ☐ eReferral ☐ Email *(Specify)* _____

If a professional referral is required, who are the specific healthcare professionals that are eligible to submit a Referral? *(e.g., Neurologists)*

Do you accept urgent referrals?

☐ No
☐ Yes, how are urgent referrals initiated? *(Specify)*

Do you accept self-referrals? *(Patients can self-refer by calling the clinic using the contact information in this profile.)*

☐ No
☐ Yes, is there a specific process? *(Specify)*

Select the mode of referral submission

☐ Phone
☐ Email *(Specify)*_____
☐ Website *(Specify)*_____

Estimated Time to Routine Appointment/ Waiting Period

Indicate how many business days it takes to book a patient's first appointment after a referral is accepted. Wait times exclude missed or no-show appointments.

☐ No ☐ Yes, *please specify*

Primary Care Alberta

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Patient Demographics

Select the age demographic of patients seen at this service. *(Select all that applies)*

☐ Pediatric *(newborn, infancy, preschool, and school age including adolescence up to and including 18 years of age)*
☐ Adults *(18 to 64 years of age)*
☐ Seniors *(65 year and older)*

Additional Service Details

Include service information that is not applicable in other fields

- Add other information about the program
- Detail information about affiliated services
- Refrain from inputting patient resources in this section, as it has a designated section.

Referral Instructions for Emergency and Urgent Providers

Provide specific instructions that will help physicians obtain referral acceptance when sending referrals from an emergency department care setting.

- Indication if healthcare service does not accept referrals from ED departments
- Minimum information required for referral acceptance by ED referral senders based upon what is reasonable for them to provide
- Any nuances or special instructions for ED referral senders

Do you accept referrals from emergency room department?

☐ No
☐ Yes, what is the minimum requirements for a referral to be accepted? *(Specify)*

Communication Process

Add your healthcare service's current communication process turnaround and update them as they changed.

a) Referral receipt to referring source within _____ days.

b) Acceptance via appointment details or wait list status letter to referring source and patient within _____ days.

c) Wait list status update every _____ days *(if applicable)*.

d) Appointment outcome to referral source within _____ days.

Primary Care Alberta

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Reason for Referral Guidelines

The referral guidelines table outlines the services provided and the client needs that qualify for referral or acceptance to your service. It also details the key requirements associated with each referral reason. Referral reason terms in the ARD are searched and selected using SNOMED-CT terminology. If the terms you require are not available, we will help identify a suitable alternative that accurately reflects your service. If you have additional reasons for referral to include, please contact ard@primarycarealberta.ca

Reason for Referral Indicate the reasons why patients are referred to your service and that you accept *Ex. Epilepsy*	**Priority Level** Routine, Urgent or Emergent *Ex. Routine*	**Access Target** Convey the clinically appropriate timeframe patients should be seen within, by reason for referral and priority level *Ex. Less than 6 months*	**Required Information or Investigations** List all the requirements that need to be included with the referral. *Ex. CT, MRI EEG results if available, Seizure frequency and Seizure description/types*	**Timing of Information/ Investigation** For example, diagnostic results and lab test must be within 1 month. *Ex. Within 3 months*	**Additional Details** Indicate supporting information about the reasons for referral. *Ex. Please note patients referred with a new or known diagnosis of epilepsy and who have been started on medication will be seen in a routine fashion.*
	Select One				
	Select One				
	Select One				
	Select One				
	Select One				

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Linked Specalists

☐ ***Not applicable to my service***

Include physicians (CPSA members) that accept referrals for your service.

Physicians Name *(First, Last)*	**CPSA Number** *(if available)*

Patient Appointment Instructions

Include specific instructions below for patients when they come for their appointment.

Please consider the following instructions:

- Bring your Alberta health care card and a piece of government issued photo ID.
- Check in at reception 15 minutes prior to your scheduled appointment time.
- You may bring a family member or significant other during your consultation.
- If you are more comfortable in a language other than English, please bring a family member or friend *(age 16 or older)* to help with translation.

Missed Appointment Guidelines

Include specific guidelines that your service follows for rescheduling or missing an appointment.

- Indicate the appropriate notice required for cancelling, rescheduling appointments and Cancellation or missed appointment fees associated
- Detail if a re-referral may be needed in case of multiple missed appointments

Virtual Appointment Information

Virtual care uses technology like telephone, video, email, and secure messaging to help patients connect with or talk to their healthcare provider when they're not in the same place.

(ex. Virtual appointments are accepted by the physicians/services discretion)

Does your service accept virtual appointments?

☐ No

☐ Yes, is there a specific process? *(Specify)*

Patient Resources

☐ **Not applicable to my service**

Add links that are helpful for patients to review about your service or specialty. *(ex. handouts, patient intake forms, etc.)*

Document Name	**URL**

Primary Care Alberta

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Location Specific Information

Describe specific instructions for the patient

- How to locate the building by providing driving directions and bus routes
- Details on how to find the clinic, program, or service within that building

Parking Instructions

Include details of the parking that is available. Indicate if parking fees are applicable, avoid detailing specific costs as this can change. Include instructions for preferred parking to easily access your clinic.

Parking Map

Add URL links to your current parking map. Please do not use Google maps as this is available within the *Patient Appointment Information section*