Alberta Health Services

Antenatal Community Care Program Referral

Please see Alberta Referral Directory>ACCP for contact information.
Link: www.albertareferraldirectory.ca

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN / MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X)	

Patient Name *(last, first)*	Home Phone
Patient Address	
Present Gestational Age	EDD

Referral from ☐ Physician Office ☐ Perinatal High Risk Clinic
☐ FMC ☐ PLC ☐ RGH ☐ SHC ☐ Other *(specify)* _____

Attending Physician	Phone	Fax

The Following Must Be Completed and Attached for Acceptance into the Program *(include with referral)*

☐ Prenatal Record Parts 1 & 2

☐ Physician Orders Form Side A&B

Reason for Referral ***(see Alberta Referral Directory for guidelines for admission criteria)***

☐ APH Last Bleeding date _____ Bleed resolved ☐ Yes ☐ No *(if no, comment below)*
Previous bleeds/Gestations *(specify)*

☐ Fetal Surveillance *(specify indications)*

☐ Hypertension Disorder ☐ Essential ☐ Hypertension in Pregnancy
1. B/P _____ proteinuria _____ other _____
2. B/P _____ proteinuria _____ other _____

Two Blood Pressures must be taken greater than 15 minutes apart

☐ Placenta Previa *(must not be vasa previa)* Bleeding date _____ # of bleeds _____
☐ Complete ☐ Partial

☐ Preterm Labour Cervical assessment _____

☐ PPROM Date ruptured_____ Stable cephalic ☐ Yes ☐ No
Frank breech? ☐ Yes ☐ No

☐ Reduced Placenta Functioning *(specify indications)*

Medications

Received Betamethasone date _____ and _____

Recent Fetal Assessment *(NST, BPP, AFI, Doppler)*

Referral Physician *(name)*	Signature	Date *(dd-Mon-yyyy)*