Alberta Health Services

Generic Referral

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)		

Ensure referral meets specific referral requirements where these are available. For more information on criteria and where to send the referral visit: www.albertareferraldirectory.ca
This referral form could also be completed electronically within the Telus Health and Accuro EMRs using the "*QuRE Consultation-Referral Request and Response*" template.

Date *(dd/Mon/yyyy)*	Refer to	
Patient Address		Phone
Referring Provider/Source		Phone
Referring Provider Address		Fax
Family Physician		
Legal Guardian Name	Phone	Relationship

Who has been informed of the reason for this referral? ☐ Patient ☐ Guardian ☐ Patient and Guardian

Additional Patient Information ☐ Patient has guardian ☐ Patient has alternative contact
☐ Patient unable to communicate well in English ☐ Patient has vision requirements
☐ Patient has hearing requirements ☐ WCB claim

Special Considerations ☐ Interpreter required ☐ Physical limitations
☐ Social / Psychological ☐ Economic Details: _____

Referral Information

Reason for referral

Type of Request ☐ Advice ☐ Consult

Priority of Referral ☐ Routine ☐ Urgent ☐ Emergent

Patient's Current Status ☐ Stable ☐ Worsening

Patient Expectation

Findings and/or investigations

Current and Past Management

Medical History

Active Medications

Allergies

Surgical History

Family History

Information given to patient

Completed By

Name	Signature	Designation	Date *(dd/Mon/yyyy)*