Path to Care Directory
Calgary Zone

SENDING A REFERRAL

APRIL 2013

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Sending a Referral

Purpose

The Calgary Zone Access and Triage Form (p. 17) is intended to provide a single standardized form across as many Calgary area specialty services as possible. The corresponding instructions and example of a previously completed referral (including corresponding patient information, tests, and investigations required by the specific specialty) have been included to assist you when completing your own referrals (p. 16). To complete each referral, you will need to refer to the Quick Reference Guide (p. 19) and Specialty Specific Guidelines (p. 57) to identify the additional information that is required.

NOTE: You are NOT required to use the Calgary Zone Access and Triage Form. Other types of referral forms are also accepted. Please, however, ensure that all required patient information is submitted when sending any referral. For a listing of required patient information please see the corresponding instructions (p. 16) and the Sending a Referral? A Reminder checklist (p. 254).

What you will find in this section

- The Calgary Zone Access and Triage Form
- The corresponding instructions. These instructions outline the patient information required when making a referral.
- An example of a completed referral (including corresponding patient information, tests, and investigations required by the specific specialty)

Sending a Referral

About the Calgary Zone Access and Triage Form

The Calgary Zone Access and Triage clinics have worked together to determine their common referral requirements and are presented in the simplified Calgary Zone Access and Triage Form. The information that is required for a complete referral may be submitted using the form or other formats (letter, EMR generated letter).

This form (located on page 17) has been developed to provide a single standardized form across as many Calgary area specialty services as possible in order to simplify the referral process for referring physicians and improve the provision of required referral information to specialists. However, the format of the referral submission is not important. A completed form, an EMR generated form or other formats will be accepted by the specialties included in this package.

Sending a Referral

Instructions

1. Familiarize yourself with the Calgary Zone Access and Triage form (p. 17)
2. Take a close look at an example of previously completed referral form along with the corresponding patient information/tests/investigations included with the referral (p. 18) to get a sense of what is required.
3. Use the Quick Reference Guide located on pages 19-56 to help you determine where you are sending the referral.
4. Compile any information required for your referral and complete the referral form. Attach extra pages as required. *See next page for requirements.*
5. Submit the completed form along with all relevant patient information. For a list of current fax and phone numbers please refer to the Quick Reference Guide.
6. For the most current copy of this form and specialty specific guidelines, please refer to: www.departmentofmedicine.com/MAS

NOTE: If a specific physician or site is chosen, there is a possibility that there will be a longer wait time for your patient than if first available appointment is selected. Additional information regarding approximate times to be seen can be found within Specialty Specific Guidelines document. Longer wait times will also likely apply to any second opinion requests.

NOTE: The Specialty Clinic will be responsible for contacting the patient and referring physician about a specialty consultation appointment.

Sending a Referral

A

B

C

D

Alberta Health Services

Calgary Zone
Access & Triage Form

Please provide as much detail as possible to ensure your patient is triaged appropriately.

Patient Information

DOB: (yyyy/mon/dd)
Last Name: First and Additional Names:
PHN: Gender:
Address: Street, City, Province, Postal Code
Telephone Number:
Email Address: Alberta Cancer Board #:
Alternate contact name: Phone:

Date: **Refer to:** **Fax:**

Referring physician/source: **Referring Prac ID:**
Address: **Phone:**
Fax:

Family physician: **Family Prac ID:**
Specialist seen previously & when: **Prior hospital admissions:** (past 2 years) **- Site(s)** ______
Currently hospitalized where ______

Reason for referral:

Diagnosis: **Date of diagnosis:** (if known)
Past medical history: **Current medications:** (provide doses and frequency for all listed) (Attach separate sheet if more space is required)
Medication allergies:

Urgency of referral:
- ☐ Urgent
- ☐ Semi urgent
- ☐ Routine

(see specific specialty guidelines for definition)

Requested Action: (if applicable)
- ☐ Confirm &/or advise as to diagnosis
- ☐ Suggest medication or management
- ☐ Assume management for this problem and return patient after care
- ☐ Assume future management of patient within area of expertise
- ☐ Provide telephone consultation (if considered appropriate by specialty)
- ☐ Education for patient

Type of referral: (if applicable)
- ☐ New referral
- ☐ Re-referral
- ☐ 2nd opinion

Requirements for Triage:
(include all relevant documentation available)
- Bloodwork
- Diagnostic imaging
- All consultant letters
- All discharge summaries
- Microbiology
- Pathology

For referral requirements of specific specialties, see relevant specialty guidelines.

Booking information:
Direct appointment by which of the following:
- ☐ Assign to next available appointment, or if no, by:
  - ☐ Specific physician: ______ (name)
  - ☐ Site: ______

Factors that may affect consultation/care:
- ☐ Language spoken ______
- ☐ Interpreter required ______
- ☐ Physical limitations ______
- ☐ Psychological ______
- ☐ Economic ______
- ☐ Other ______

Is this patient a WCB or insurance patient? ☐ Yes ☐ No

Signature: ______ **Designation:** ______ **Date:** ______

Fax the form (or the indicated information in other legible format) to the number listed for that specialty.
You will receive notification of receipt of this form within 2 working days of receipt.

November 2010 - print version www.departmentofmedicine.com/MAS

Be sure to provide

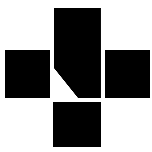
A. Your office's direct phone number for healthcare professionals rather than a general office number to expedite the process.

B. The Calgary Zone Access and Triage form requirements including information regarding a patient's demographics, symptoms, medications etc.

C. Your evaluation of urgency of referral based on the Specialty Specific Guidelines. Doing so, will assist each Specialty in determining referral urgency in a more timely manner.

D. The Specialty Specific Guideline requirements (pages 57-235) including any information, tests, or investigations required by the specialty for triage.

NOTE: The guidelines provided for each Specialty are a reference tool for referring physicians only. They are not exhaustive lists and are not intended to replace the clinical judgement of the referring source. All referrals will also continue to be individually reviewed and triaged by the receiving Specialty.



Alberta Health Services

Calgary Zone Access & Triage Form

Please provide as much detail as possible to ensure your patient is triaged appropriately.

Patient Information

DOB: (yyyy/mon/dd)

Last Name: First and Additional Names:

PHN: Gender:

Address: Street, City, Province, Postal Code

Telephone Number:

Email Address: Alberta Cancer Board #:

Alternate contact name: Phone:

Date:	**Refer to:**	**Fax:**

Referring physician/source:	**Referring Prac ID:**
Address:	**Phone:** **Fax:**
Family physician:	**Family Prac ID:**
Specialist seen previously & when:	**Prior hospital admissions:** (past 2 years) **- Site(s)** ______ Currently hospitalized where ______

Reason for referral:

Diagnosis:	**Date of diagnosis:** (if known)
Past medical history:	**Current medications:** (provide doses and frequency for all listed) (Attach separate sheet if more space is required) **Medication allergies:**

Urgency of referral:

- ☐ Urgent
- ☐ Semi urgent
- ☐ Routine

(see specific specialty guidelines for definition)

Requested Action: (if applicable)

- ☐ Confirm &/or advise as to diagnosis
- ☐ Suggest medication or management
- ☐ Assume management for this problem and return patient after care
- ☐ Assume future management of patient within area of expertise
- ☐ Provide telephone consultation (if considered appropriate by specialty)
- ☐ Education for patient

Type of referral: (if applicable)

- ☐ New referral
- ☐ Re-referral
- ☐ 2nd opinion

Requirements for Triage:
(include all relevant documentation available)

- Bloodwork
- Diagnostic imaging
- All consultant letters
- All discharge summaries
- Microbiology
- Pathology

For referral requirements of specific specialties, see relevant specialty guidelines.

Booking information:
Direct appointment by which of the following:

- ☐ Assign to next available appointment, or if no, by:
  - ☐ Specific physician: ______ (name)
  - ☐ Site: ______

Factors that may affect consultation/care:

- ☐ Language spoken ______
- ☐ Interpreter required ______
- ☐ Physical limitations ______
- ☐ Psychological ______
- ☐ Economic ______
- ☐ Other ______

Is this patient a WCB or insurance patient? ☐ Yes ☐ No

Signature: ______ **Designation:** ______ **Date:** ______

Fax the form (or the indicated information in other legible format) to the number listed for that specialty.
You will receive notification of receipt of this form within 2 working days of receipt.

Completed referral form and required documentation

Calgary Zone Access & Triage Form

Please provide as much detail as possible to ensure your patient is triaged appropriately.

Patient Information

	DOB: 1967/Jul/24
Last Name: Doe	First and Additional Names: Jane Anne
PHN: 56789-1234	Gender: Female
Address: Street, City, Province, Postal Code: 12 Somewhere Road, Someplace, Alberta	
Telephone Number: (403) 222-3333	
Email Address: jadoe@email.ca	Alberta Cancer Board #:
Alternate contact name:	Phone:

Date: 2012/Nov/07	**Refer to:** Rheumatology Fax (403) 955-8199
Referring physician/source: Dr. Someone	**Referring Prac ID:** 23456-7890
Address: 45 Medical Crescent Elsewhere, Alberta	**Phone:** (403) 922-2267 **Fax:** (403) 922-2270
Family physician: same	**Family Prac ID:** above
Specialist seen previously & when: -	**Prior hospital admissions:** (past 2 years) **- Site(s)** - Currently hospitalized where -

Reason for referral:

Please assess this 45-yr-old woman with suspected inflammatory joint disease. Swelling and pain in both wrists, her second and third MCP joints and feet x 3 mths. Stiff for 2-3 hours in am and complains of fatigue. Unable to continue work as a NA. Relevant blood work Oct 31/12: RF = negative; ANA = negative; ESR = 45; CRP = 38. CBC, creatinine, liver function all normal

Diagnosis: ? Rheumatoid Arthritis	**Date of diagnosis:** (if known)
Past medical history: unremarkable; otherwise well	**Current medications:** (provide doses and frequency for all listed) (Attach separate sheet if more space is required) - **Medication allergies:** NKA

Urgency of referral:
- [ ] Urgent
- [x] Semi urgent
- [ ] Routine

(see specific specialty guidelines for definition)

Requested Action: (if applicable)
- [x] Confirm &/or advise as to diagnosis
- [x] Suggest medication or management
- [ ] Assume management for this problem and return patient after care
- [ ] Assume future management of patient within area of expertise
- [ ] Provide telephone consultation (if considered appropriate by specialty)
- [ ] Education for patient

Type of referral: (if applicable)
- [x] New referral
- [ ] Re-referral
- [ ] 2nd opinion

Requirements for Triage:
(include all relevant documentation available)
- Bloodwork
- Diagnostic imaging
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- Pathology

For referral requirements of specific specialties, see relevant specialty guidelines.

Booking information:
Direct appointment by which of the following:
- [x] Assign to next available appointment, or if no, by:
  - [ ] Specific physician: ______ (name)
  - [ ] Site: ______

Factors that may affect consultation/care:
- [ ] Language spoken ______
- [ ] Interpreter required ______
- [ ] Physical limitations ______
- [ ] Psychological ______
- [ ] Economic ______
- [ ] Other ______

Is this patient a WCB or insurance patient? [ ] Yes [x] No

Signature: ______ **Designation:** ______ **Date:** 2012/Nov/07

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You will receive notification of receipt of this form within 2 working days of receipt.