Alberta Health Services

FACULTY OF MEDICINE | UNIVERSITY OF CALGARY

Medical Specialists & Medical Services Central 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: (yyyy/mon/dd)	**Refer to:** (program/specialty/clinic)	**Fax:** (see specialty info)

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:** (yyyy/mon/dd) ______

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 2008