Alberta Health Services

FACULTY OF MEDICINE | UNIVERSITY OF CALGARY

Calgary Zone
Central Access & Triage Form

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

Patient Information

DOB:

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:** - Enter Program/Specialty/Clinic Name and Fax number or use drop list

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.