

## Calgary Zone Central Access & Triage Form

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

<b>Patient Information</b>	
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: _____

<b>Date:</b> _____	<b>Refer to:</b> _____	<b>Fax:</b> _____
<b>Referring physician/source:</b> _____	<b>Referring Prac ID:</b> _____	
<b>Address:</b> _____	<b>Phone:</b> _____	
	<b>Fax:</b> _____	
<b>Family physician:</b> _____	<b>Family Prac ID:</b> _____	
<b>Specialist seen previously &amp; when:</b> _____	<b>Prior hospital admissions:</b> (past 2 years) - <b>Site(s)</b> _____ Currently hospitalized where _____	
<b>Reason for referral:</b> _____ _____ _____		
<b>Diagnosis:</b> _____	<b>Date of diagnosis:</b> (if known) _____	
<b>Past medical history:</b> _____	<b>Current medications:</b> (provide doses and frequency for all listed) (Attach separate sheet if more space is required) _____	
	<b>Medication allergies:</b> _____	
<b>Urgency of referral:</b> <input type="checkbox"/> Urgent <input type="checkbox"/> Semi urgent <input type="checkbox"/> Routine (see specific specialty guidelines for definition)	<b>Requested Action:</b> (if applicable) <input type="checkbox"/> Confirm &/or advise as to diagnosis <input type="checkbox"/> Suggest medication or management <input type="checkbox"/> Assume management for this problem and return patient after care <input type="checkbox"/> Assume future management of patient within area of expertise <input type="checkbox"/> Provide telephone consultation (if considered appropriate by specialty) <input type="checkbox"/> Education for patient	<b>Type of referral:</b> (if applicable) <input type="checkbox"/> New referral <input type="checkbox"/> Re-referral <input type="checkbox"/> 2 <sup>nd</sup> opinion
<b>Requirements for Triage:</b> (include all relevant documentation available) • Bloodwork • Diagnostic imaging • All consultant letters • All discharge summaries • Microbiology • Pathology  <b>For referral requirements of specific specialties, see relevant specialty guidelines.</b>	<b>Booking information:</b> Direct appointment by which of the following: <input type="checkbox"/> Assign to next available appointment, or if no, by: <input type="checkbox"/> Specific physician: _____ (name) <input type="checkbox"/> Site: _____ Factors that may affect consultation/care: <input type="checkbox"/> Language spoken _____ <input type="checkbox"/> Interpreter required _____ <input type="checkbox"/> Physical limitations _____ <input type="checkbox"/> Psychological _____ <input type="checkbox"/> Economic _____ <input type="checkbox"/> Other _____ Is this patient a WCB or insurance patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Signature:</b> _____ <b>Designation:</b> _____ <b>Date:</b> _____		

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.