CWC Primary Care Centre referral form

PrimaryCare Network
CALGARY WEST CENTRAL

MON TO FRI: 9 A.M. – 9 P.M. | WEEKENDS/HOLIDAYS: 9 A.M. – 4 P.M.

Access Appointment Service
Phone: 403.249.9907 | Fax: 403.258.2748
☐ Referral

Inclusion criteria: Issues/concerns warranting a family physician visit within **24 hours**.
During after-hours or on weekends, please have your patient call Health Link at 811.

Senior Services | Phone: 403.686.0020 | Fax: 403.229.2742

Reason for referral:

☐ Baseline cognitive assessment
☐ Cognitive or behavioural changes
☐ Driving concerns
☐ Falls/frailty
☐ Functional assessment
☐ Medication issues
☐ Caregiver burden
☐ Resource navigation
☐ Other: _______________

Social Work | Phone: 403.686.0020 | Fax: 403.229.2741

☐ Adults ☐ Children, youth, and family
(Evening appointments available, if warranted)

Reason for referral:

☐ Abuse/domestic violence
☐ Basic needs
☐ Caregiver support
☐ Financial stressors
☐ Mental health resource navigation
☐ Other: _______________

For referrals to Senior Services or Social Work: If a home visit is deemed necessary, please indicate if there are potential safety concerns in the home for either the client or provider. **Specify details below or request a call to discuss**.

Safety of Client
☐ None/unknown
☐ Allergies, fall risk, smoking in home, altered cognition, lack of equipment, other safety concerns.

Safety of Provider
☐ No identified risk
☐ Pets, known active substance abuse, behavioural concerns, other safety concerns.

Patient information *Affix patient label or enter information here*

Date: ________________________

Patient name: ____
PHN: __________________ DOB (yyyy/mm/dd): ________________
Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose ☐ Other: _________
Address: ____
City: __________________ Province: ____________ Postal code: ________________
Telephone (H): __________________________ (C): ______________________________

Preferred pronouns: ☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other: ________________________________
Preferred contact person (if applicable): ___________________________________ Relationship: _____________________
Preferred contact number (H): __________________________ (C): ______________________________

Required for all referrals: Please specify **reason for referral** in the space below and **attach any relevant information**.

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Physician information

Referring physician name: _______________________________ Clinic name: ___________________________________
Clinic phone number: ______________________ Clinic fax number: ______________________
Family physician name (if different): _________________________
CWC PCN regulated health professional (if applicable): _________________________________