Alberta Health Services

Outpatient IV Therapy Clinic Medical Referral

Please complete the following and fax to the Outpatient IV Clinic 780-735-5642. Appointment date and time will then be faxed to you.

Patient label placed here (if applicable) or if labels are not used, minimum information below is required.	
Name *(last, first)*	
Birthdate *(yyyy-Mon-dd)*	Gender ☐ Male ☐ Female
PHN / ULI	

Reason for Current Treatment				
Current Blood Work				
Hgb			Other	
Past Medical History ***(please check all that apply)***				
☐ Diabetes				
☐ Asthma / COPD				
☐ Heart Disease / CVA / CHF				
☐ Mental Disability *(specify)*				
☐ Past Surgical Intervention *(last 5 years)*				
☐ Other				
Best Possible Medication History ☐ **see attached list**				
Drug Name			Dosage and Frequency	
Allergies ☐ **no known allergies**				
☐ Yes *(specify)*				
Activities of Daily Living				
Mobility	☐ Independent	☐ Assist with 1 person	☐ Walker / Cane	☐ Wheelchair
Diet / Feeding	☐ Independent	☐ Requires assistance	☐ Special Diet *(specify)*	
Elimination	☐ Independent	☐ Requires assistance	☐ Incontinent	

Physician Name* *(please print)*	Contact / Pager #
Alternate* *(please print)*	Contact / Pager #
Physician Signature	Date *(yyyy-Mon-dd)*

*** While the patient is in the clinic, a physician contact or alternate MUST be immediately available when paged or contacted by phone.**