Alberta Health Services

Service Profile Submission for Private Services

Alberta Referral Directory

The Alberta Referral Directory (ARD) is an online directory that centralizes referral information for specialty care options across Alberta. The ARD eases the complexities of the referral process by eliminating the need to search, update and publish documents in multiple places throughout the province. For more information visit www.ahs.ca/ard

Please complete this form, and send to ARD using “submit” button to get your Service Profile listed on the ARD. The ARD Administrator will contact you before your profile is published.

Email ard@ahs.ca if you have questions or require assistance.

Service Information *(Provide official name of this service)*

Service Name

Short Service Description *(Write a one sentence statement of what this service provides)*

Service Description *(Intended to help clients determine if a service is suitable for their needs and what to expect when they access the service)*

Provide details about the program or service in clear, brief terms (less than 500 characters).

- *Use plain language*
- *Open with a complete sentence followed by items in point form*
- *Indicate the type of service delivered (e.g., assessment, treatment, prevention, education, etc.)*
- *Omit details intended to promote the service*

Additional Service Details *(Include any other relevant information valuable for referring health care providers and patients, may include important notes and links to resources)*

Key Providers *(List the types of providers who deliver this service e.g., social workers, registered nurses, doctors, health inspectors, etc.)*

Location Information

Does your service have multiple locations?

☐ Yes ➔ Complete the section below **for one location**, and an ARD administrator will contact out to discuss additional locations when your submission is received.

☐ No ➔ Complete the section below

Building/Facility Name: *(i.e. Centre, Plaza or professional building name)*

Street Address

☐ Confidential

Suite/Room Number	City	Postal	Prov

General Phone	Referral Phone	General Fax	Referral Fax

Toll Free Number	Email

Mailing address (☐ same as above)

Website *(paste URL)*	Email

Location Information *(e.g., Mon-Fri 8:00-4:15, Sat 10:00- 2:00, closed on Sundays)*

☐ Service Operates 24/7

Referral Information

Estimated time to routine appointment?
(Choose the appropriate timeframe option that best captures how long it takes for a patient's initial appointment to be booked from when the referral is accepted. Note: Self-referral or by phone may be same day)

Select one

Routine Referral Process *(Describe how routine referrals are submitted, received, and managed by your service)*

Referral Information *(continued)*

Urgent Referral Process *(Describe process for escalating a referral that is considered urgent in nature. You may want to include who to connect with to discuss, or add specific criteria that can help the referring health care provider determine the priority status is urgent)*

Emergent Referral Process *(Describe process for escalating a referral that is considered emergent in nature e.g., Call to discuss if you think your patient may need to be seen same day or next day)*

Referral Form *(Add your service's referral form web address below)*

☐ Use AHS Generic Referral

The ARD does NOT accept PDFs or Word documents. Your referral form must be accessible on a website *(not saved on your drive/must be publicly searchable).*

Eligibility Requirements *(Describe your service's considerations, diagnoses, symptoms, or indications your service might specifically accept patients for e.g., age, lymph node greater than 1 cm, BMI less than 35, at a moderate to high risk for inherited genetic conditions, etc.)*

Referral Resources *(Check all that apply to your service. The corresponding link[s] will be displayed on the service profile)*

☐ Connect MD
☐ eReferral Advice Request
☐ eReferral Consult Request
☐ Specialist LINK

Pathways *(Add links to the pathways that are associated with your service or specialty)*

URL _____

Display Text _____

Referral Guidelines

List one reason for referral per section, the ARD administrator will call to discuss your full list of reasons for referral.

***Note:** Terms listed under "Reasons for Referral" may need to be adjusted to align with SNOMED CT international terminology. ARD will assist with this.

Routine Reason for Referral			
List Reasons for Referral* List a specific **routine** reason that a referring provider would request the consultation.	**Required Information/ Investigation** Information/Investigation required for processing and triaging a referral. Example: - Describe abdominal pain - duration, severity, frequency - CBC, lytes - BUN, Creatinine - Other labs/diagnostics?	**Timing of Information/ Investigation** Indicate the acceptable time frame for each required information/ investigation from the available drop down options.	**Additional Details** Beyond the processes indicated elsewhere there may be additional directions/information related to specific reason(s) for referral *Note: If the additional information does not fit within this box, please indicate "ARD Administrator please call to discuss".
		Select one	
		Select one	
Urgent Reason for Referral *(Fill out this section if applicable)*			
List Reasons for Referral* List a specific **urgent** reason that a referring provider would request the consultation.	**Required Information/ Investigation** Information/Investigation required for processing and triaging a referral. Example: - Describe abdominal pain - duration, severity, frequency - CBC, lytes - BUN, Creatinine - Other labs/diagnostics?	**Timing of Information/ Investigation** Indicate the acceptable time frame for each required information/ investigation from the available drop down options. Example: - Within 1 year - Within 1 month	**Additional Details** Beyond the processes indicated elsewhere there may be additional directions/information related to specific reason(s) for referral *Note: If the additional information does not fit within this box, please indicate "ARD Administrator please call to discuss".
		Select one	
		Select one	
Emergent Reason for Referral *(Fill out this section if applicable)*			
List Reasons for Referral* List a specific **emergent** reason that a referring provider would request the consultation.	**Additional Details** Beyond the processes indicated elsewhere there may be additional directions/information related to specific reason(s) for referral		

Missed Appointment Guidelines *(Indicate how patients can reschedule or cancel an appointment. Also indicate any consequences if patient "no shows" for an appointment e.g., "after three missed appointments without valid reasons a new referral will be required".)*

Communication Process - see CPSA Standards of Practice - Referral Consultation

Communication of referral receipt to referral source will occur within _____ calendar days.

Communication of appointment details or wait list status to patient and referral source will occur within _____calendar days.

Communication of initial appointment outcomes to referral source will occur within _____ calendar days.

Virtual Appointment Information *(Virtual care uses technology like telephone, video, email, and secure messaging to help connect patients to their healthcare provider when they're not located in the same place. Sometimes in-person visits are not needed or possible. Healthcare providers can offer virtual visit using telephone or video calls.)*

Referral Contact Information

Referral Phone

Referral Fax

Other Information

Directions *(Describe specific instructions on how to navigate to this location and the clinic, program, or service inside e.g., Located on the fourth floor of building C. Once on the fourth-floor, head towards rooms 413-423, the clinic is the third door from the end)*

Parking instructions *(Include instructions for preferred parking to easily access your clinic, and if parking is free or if fees are applicable, avoid detailing specific cost as this can change)*

Wheelchair Accessibility Description

Requester Contact Information	
Primary Contact First Name	Last Name
Phone	E-mail
Secondary Contact First Name	Last Name
Phone	E-mail

Email Submit