Alberta Health Services

Alberta Healthy Living Program South Zone
Chronic Disease Referral

Please complete all sections of this form and return to appropriate location:

Brooks inquires please call 1-866-795-9709 or print and send by fax to: 1-403-501-3327
Lethbridge and rural area inquires please call 1-866-506-6654 or print and send by fax to: 1-403-317-0435
Medicine Hat and rural area inquires please call 1-866-795-9709 or print and send by fax to 1-403-528-5602

Client Demographics ***(affix client label here if applicable)***	
Client Name	Date of Birth
Address	Preferred Phone
Personal Health Care Number	Alternate Phone
Family Physician	Referral Date
Referral source and contact phone number	

Patient needs/additional Information:

☐ Hearing and/or visually impaired *(describe)*:________________________________

☐ Interpreter Required? Preferred language ______________________

Does the referred client have a legal guardian/agent?

☐ No ☐ Yes, Name ___________________________ Contact Phone Number _________________

☐ Unable to participate in group *(describe)*:________________________________

Adult General Health Education – These are group based education classes, option to be delivered by telehealth.

Health Education Group Classes:

- ☐ Basic Diabetes Management (Hemoglobin A1C less than 8.5)
- ☐ Better Choices, Better Health® Self-Management (6 class series)
- ☐ Better Choices, Better Health® Chronic Pain (6 class series)
- ☐ COPD Education Class (2 class series)
- ☐ Energy Management (2 class series)
- ☐ Explaining Pain
- ☐ Getting Started: Prerequisite for Weight Management
- ☐ Grocery Store Tour
- ☐ Healthy Eating for Risk Reduction
- ☐ Heart Failure Education
- ☐ Managing Emotional Eating (3 class series)
- ☐ Managing Stress for Better Health and Wellness (2 class series)
- ☐ Moving You Towards Better Sleep
- ☐ Taking Care of You – Vascular Risk Reduction

Risk Reduction – Please indicate diagnosis to ensure patient is offered appropriate class

Diagnosis:

☐ Stroke/Transient Ischemic Attack ☐ Hypertension ☐ Dyslipidemia
☐ Peripheral Vascular Disease ☐ Chronic Kidney Disease (GFR 30-60)
☐ Cardiovascular Risk: Framingham Risk Score:__________

Specialty Support: Specialty services which may include an interdisciplinary team and/or individual consult as appropriate. See comment section below to provide more detail as needed

☐ **Supervised Exercise** – provide physician signature (required) and reason for medical supervision/referral for exercise.

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☐ **Cardiac Rehabilitation**

☐ **Heart Function Clinic**-• includes Heart Failure Education class.

Provide

1) Consult letter outlining patient history and physical
2) ECHO (completed in the last 12 months).

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☐ **Diabetes** (Please ensure Hg A1C and GFR/creatinine is completed within the last 6 months)

☐ New diagnosis
☐ Gestational ☐ Pregnancy planning for pre-existing diabetes
☐ Pre-existing diabetes and pregnancy
☐ Type 1 ☐ Type 2
☐ Insulin Pump Therapy - Is the patient already using an Insulin pump?
☐ Yes ☐ No

☐ Medication initiation or adjustment - Is the patient?
☐ Type 1 ☐ Type 2

☐ **Respiratory**

☐ Chronic Obstructive Pulmonary Disease (COPD) –PFT or spirometry done within 6 - 12 months if available (confirmation of COPD).
☐ Recent flare up/lung infection/use of antibiotics or prednisone within past 4-6 weeks?
☐ Asthma – PFT or spirometry done with past 6 months for patients over the 6 years of age
☐ Recent flare up/lung infection/use of antibiotics or prednisone within past 4-6 weeks?

☐ **Chronic Pain – includes Explaining Pain class**

Referral Criteria -18 years of age or older
- Pain greater than 3-6 months
- Stable medication regime (no recent titration)

☐ **Nutrition**

(Required) Patient Height _________ Weight _________ Date *(dd-Mon-yyyy)* __________________
☐ Allergies/intolerances (specify) _____________________
☐ Disordered Eating: (specify) _________________________ **Physician referral** required
☐ Feeding Difficulties (picky eating, texture progression, limited food choices, and feeding skill issues) (specify) ____________________________
☐ Gastrointestinal disease/concern (specify) ________________________
☐ Malnutrition (unintentional weight loss/poor appetite)
☐ Pediatric Weight Management
☐ Pregnancy
☐ Suboptimal Growth and Weight
☐ Vitamin/Mineral Deficiency (specify) ____________________
☐ Other (specify) ________________________________

☐ **Overweight/Obesity Management**

(Required) Patient Height _________ Weight _________ Date *(dd-Mon-yyyy)* __________________
☐ **Weight Management Program** (10 weeks group series or individual consult as appropriate) **and/or**
☐ **Bariatric Specialty Clinic (located in Medicine Hat)** Age 64 or younger at time of referral and must be a non-smoker.
Provide: Consult Letter outlining patient history.
Referral Criteria: Must meet **one** of the following:
BMI Greater than or equal to 40 **or** BMI greater than or equal to 35 with any weight- related co-morbidity. Please identify:
☐ Cardiovascular disease ☐ Type 2 diabetes ☐ Sleep apnea ☐ Gall bladder disease
☐ Osteoarthritis ☐ Hypertension ☐ Chronic pain

Comments

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