



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:	
<input type="checkbox"/> Hearing and/or visually impaired (<i>describe</i>): _____	
<input type="checkbox"/> Interpreter Required? Preferred language _____ Does the referred client have a legal guardian/agent? <input type="checkbox"/> No <input type="checkbox"/> Yes, Name _____ Contact Phone Number _____	
<input type="checkbox"/> Unable to participate in group (<i>describe</i>): _____	
Adult General Health Education – These are group based education classes, option to be delivered by telehealth.	
Health Education Group Classes:	
<input type="checkbox"/> Basic Diabetes Management (Hemoglobin A1C less than 8.5)	
<input type="checkbox"/> Better Choices, Better Health [®] Self-Management (6 class series)	
<input type="checkbox"/> Better Choices, Better Health [®] Chronic Pain (6 class series)	
<input type="checkbox"/> COPD Education Class (2 class series)	
<input type="checkbox"/> Energy Management (2 class series)	
<input type="checkbox"/> Explaining Pain	
<input type="checkbox"/> Getting Started: Prerequisite for Weight Management	
<input type="checkbox"/> Grocery Store Tour	
<input type="checkbox"/> Healthy Eating for Risk Reduction	
<input type="checkbox"/> Heart Failure Education	
<input type="checkbox"/> Managing Emotional Eating (3 class series)	
<input type="checkbox"/> Managing Stress for Better Health and Wellness (2 class series)	
<input type="checkbox"/> Moving You Towards Better Sleep	
<input type="checkbox"/> Taking Care of You – Vascular Risk Reduction	
Risk Reduction – Please indicate diagnosis to ensure patient is offered appropriate class	
Diagnosis:	
<input type="checkbox"/> Stroke/Transient Ischemic Attack	<input type="checkbox"/> Hypertension <input type="checkbox"/> Dyslipidemia
<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Chronic Kidney Disease (GFR 30-60)
<input type="checkbox"/> 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	
<input type="checkbox"/> Supervised Exercise – provide physician signature (required) and reason for medical supervision/referral for exercise. _____	
<input type="checkbox"/> Cardiac Rehabilitation	
<input type="checkbox"/> Heart Function Clinic • includes Heart Failure Education class. Provide <ol style="list-style-type: none"> 1) Consult letter outlining patient history and physical 2) ECHO (completed in the last 12 months). 	

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
