



Client Demographics (affix client label here if applicable)

Client Name	Date of Birth
Address	Home Phone
Personal Health Care Number	Cell Phone
Family Physician	Referral Date
Referral source and contact phone number	
Does the referred client have a legal guardian/agent? <input type="checkbox"/> No <input type="checkbox"/> Yes, name and contact phone number	
<input type="checkbox"/> Unable to participate in group education (describe)	
<input type="checkbox"/> Hearing or visual impairment (describe)	
<input type="checkbox"/> Mobility limitations (describe)	
<input type="checkbox"/> Unable to read or speak English	First language spoken is
Translator name and contact phone number	

Specialty Services (check primary reason for referral)

<input type="checkbox"/> Better Choices, Better Health™ (Stanford self management series) • Includes a 6 week workshop that helps you take control of your health		
<input type="checkbox"/> Cardiac Rehabilitation • Includes cardiac education, assessment and referral to exercise		
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) Program • Includes respiratory education, assessment and referral to exercise		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Impaired Fasting Glucose (IFG) and/or Impaired Glucose Tolerance (IGT) <input type="checkbox"/> Insulin Initiation and Adjustment. Physician orders attached. <input type="checkbox"/> Insulin Therapy <input type="checkbox"/> New Pump Assessment <input type="checkbox"/> Existing Pump Therapy <input type="checkbox"/> Non-Insulin Medication(s) Initiation and Adjustment. Physician orders attached. <input type="checkbox"/> Pediatrics <input type="checkbox"/> Pregnancy <input type="checkbox"/> Gestational <input type="checkbox"/> Type 1/ Type 2 <input type="checkbox"/> Preconception <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	
<input type="checkbox"/> Heart Function Clinic (Specialist Consult with Interdisciplinary Services, <u>Physician Referral Required</u>) <input type="checkbox"/> Consult letter attached		
<input type="checkbox"/> Heart Failure Education		
<input type="checkbox"/> Nutrition	Client's Height	Client's Weight
Primary reason for referral: <input type="checkbox"/> Healthy Weight Gain in Pregnancy		
<input type="checkbox"/> Risk Factor Management <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Hypertension <input type="checkbox"/> Lifestyle Class		
<input type="checkbox"/> Stroke/Transient Ischemic Attack (TIA) Education		
<input type="checkbox"/> Supervised Exercise		
<input type="checkbox"/> Weight Management		

Comments

Office Use Only Appointment scheduled on

Medicine Hat	Phone 403-529-8969 Fax 403-528-5602	Toll Free: 1-866-795-9709
Brooks	Phone 403-793-6659 Fax 403-501-3327	email: living.healthy@albertahealthservices.ca