Alberta Health Services

Alberta Healthy Living Program Referral

- This form is for group supervised exercise and one on one nutrition counselling services. Please visit our ARD profile for more information on patient criteria, classes, how your patients can register, and where to send this referral: www.albertareferraldirectory.ca
- Self-referrals to the group exercise program are accepted.
- Exercise patients must be attached to a Family Physician or Nurse Practitioner in the event that additional medical clearance is required.
- Self-referrals to nutrition counselling are no longer accepted.
- Patients can self-refer to our self-management program and health education classes through our website: http://www.ahs.ca/ahlp
- Patients must be 18 years or older.

Patient Information *(or place label here)*

Date *(dd-Mon-yyyy)*	First Name	Last Name
Date of Birth *(dd-Mon-yyyy)*	Personal Health Number	Administrative Gender ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose

Address	City	Postal Code	Phone

Referring Provider

First Name	Last Name	Discipline

Address	Phone	Fax

Family Physician	Phone

Factors that may affect Consultation/Care

Interpreter required ☐ No ☐ Yes *(if yes, specify language)* _____

☐ Physical limitations ☐ Social/Psychological ☐ Economic ☐ Other _____

Details _____

Reasons for Referral

Indicate a referral to Nutrition counselling, Supervised Group Exercise **or both** by checking appropriate boxes below.

☐ **Nutrition Counselling Appointment** *(confirm primary reason to see a Registered Dietitian)*

- ☐ Celiac disease
- ☐ Colitis
- ☐ Diverticular disease
- ☐ Eosinophilic Esophagitis *(EOE)*
- ☐ Fatty Liver
- ☐ Gastroparesis
- ☐ GERD
- ☐ Hemochromatosis
- ☐ Hepatitis
- ☐ High Output Ostomy
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Liver cirrhosis
- ☐ Malnutrition
- ☐ Pancreatitis
- ☐ Primary Sclerosing Cholangitis
- ☐ Peptic Ulcer
- ☐ Short bowel
- ☐ Swallowing concerns/dysphagia
- ☐ Unexplained weight loss
- ☐ Other *(specify)* _____

*If we offer a group education class for one of your patient's primary reason(s) for referral, your patient **will be required to attend the group education class** related to their nutritional concern prior to being eligible for a nutrition counselling appointment.*

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Reasons for Referral *(continued)*

☐ **Supervised Exercise** *(Physician or health care provider and self-referral accepted)*

To be eligible for a referral to supervised group exercise classes, the patient must meet the following requirements:

- Must be attached to a Family Physician or Nurse Practitioner
- Must have at least one chronic health condition
- Able to transfer independently and ambulate with or without a gait aid for approximately 100 metres
- Must be able to manage their health condition independently
- Repeat referrals will be screened to determine eligibility to repeat the program. Patient must have a new chronic condition or significant change in health status to meet eligibility criteria.

Health History

List all relevant health conditions applicable to this patient.

Non-Physician Health Care Providers: your patient may be required to see their physician to obtain clearance prior to starting our exercise program.

For Exercise Only - Physician or Nurse Practitioner Evaluation

☐ I confirm that this patient has been evaluated for risk of cardiovascular, pulmonary, and metabolic disease and is medically stable to proceed with exercise.

☐ No precautions or contraindications are applicable; OR

☐ The exercise precautions and/or contraindications listed are applicable *(specify below)*

Physician/Health Practitioner/Provider Name	Designation	Date *(dd-Mon-yyyy)*