Alberta Health Services

Alberta Healthy Living Program Referral
(Adults and Pediatrics) Central Zone

Check Primary Reason for Referral
(You may choose more than one)
Individual Care Appointments may be booked if group education is not available or appropriate for the client.
Further information on the below services please visit:
http://www.albertahealthservices.ca/info/cdmcentralzone.aspx
Click on the tab – Available Services

Please complete all sections of this form and return by email to **AHS.CZAlbertaHealthyLivingProgram.admin@ahs.ca** or print and send by fax to **1.877.314.6993.** For inquiries please call **1.877.314.6997** or send an email to the address above.

Client Name	Date of Birth *(dd-Mon-yyyy)*	Gender
Personal Health Number (PHN)	Preferred Phone	Alternate Phone
Mailing Address	City	Province / Postal Code
Alternate Contact Name *(optional)*	Relationship	Contact Number *(if different from above)*
Family Physician	Specialist	

Patient Needs/Additional Information

Does the referred client have a legal guardian/agent ☐ No ☐ Yes *please provide*
▶Name _____ and contact phone number _____
☐ Unable to participate in group education *(please specify)* _____
☐ Hearing, visual impairment *(please specify)* _____
☐ Activity/Mobility limitations. Requires oxygen, falls risk etc. *(please specify)* _____
☐ Unable to read or speak English *(please specify language)* _____
☐ Social/Mental Health Concerns *(please specify)* _____

Additional Comments

Type of Referral *(Check all that apply)*
☐ Health Education - Self-Management Education *(Adult Services)*/Supervised Exercise *(Adult Services)*
☐ Diabetes Specialty Care *(Pediatric and Adult Services)*
☐ Both Services

Health Education – Self-Management Education (Adult Services)
☐ Better Choices, Better Health™: Self-Management Education ☐ Weight Management Strategies
☐ Diabetes the Basics: At Risk/Pre-Diabetes/Type 2 Diabetes ☐ Managing Emotional Eating
☐ Heart Wise: Managing Cholesterol and Blood Pressure

Healthy Lifestyle Series: ☐ Ready for Change ☐ Sleep Well ☐ Stress Less
☐ Time to Move ☐ Label Reading ☐ Other _____

Supervised Exercise (Adult Services)
☐ Pulmonary Rehabilitation ☐ Supervised Exercise Program ☐ Other _____

Diabetes Specialty Care (Pediatric and Adult Services)
☐ Newly Diagnosed Type 1 Diabetes - Date of Diagnosis *(dd-Mon-yyyy)* _____
☐ Type 1 Diabetes Care
☐ Pregnancy Planning for Clients with Diabetes
☐ Gestational Diabetes ☐ Pre-existing Diabetes and Pregnancy (Type 1 or Type 2 Diabetes)
☐ Insulin Pump Therapy Consult. Is the patient already using an insulin pump? ☐ Yes ☐ No
☐ Endocrinology Consult - Adult
☐ Endocrinology Clinic - Pediatric
☐ Nephropathy Care
☐ Type 2 Complex Care - When targets not achieved/improving with treatment ☐ On OHA's ☐ On Insulin
☐ Other_____

Staff will access lab work, medications, diagnostic imaging, and consult letters from Netcare/Meditech if necessary. Lab work may be requested if not current.

Referring Health Care Provider *(please print)*	**If required, also include communication to** *(please print)*
Name	Name
Position	Position
Phone	Phone
Fax	Fax
Is client aware of referral ☐ Yes ☐ No	Date *(dd-Mon-yyyy)*