

For more information about program services, criteria and where to send the referral visit:

www.albertareferraldirectory.ca

- Patients must be 18 years or older.
- This referral form is for our one on one nutrition counselling services and our group exercise program. Alternatively, self-referrals are accepted for one on one nutrition services, group education, self-management workshops, and group exercise. Please visit our ARD profile for more information on classes and how your patients can register.
- We accept self-referrals to the group exercise program, however, patients must be attached to a Family Physician or Nurse Practitioner. Physicians or Nurse Practitioners referring to exercise are asked to provide a signature clearing patients to exercise (please see page 2).
- Incomplete and illegible referrals will not be accepted.

Patient Information <i>(Place patient label here)</i>		Referral Source
Name <i>(Last, First)</i>		Name <i>(Last, First)</i> Discipline
Address		Signature
City	Postal Code	Phone
Phone		Fax
Personal Health Number		Family Physician Name <i>(Last, First)</i>
Date of Birth <i>(yyyy-Mon-dd)</i>		Phone
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> The patient's gender identity is _____		

List or attach any information that may affect consultation/care	Explanation of Need(s)
<input type="checkbox"/> Language barrier	
<input type="checkbox"/> Physical limitation(s) or fall risk	
<input type="checkbox"/> Cognitive concerns <i>(provide completed cognitive assessment if available)</i>	
<input type="checkbox"/> Social/Behavioural/Psychological	
<input type="checkbox"/> History of violence or aggression	

Nutrition Counselling Appointment

Please check the primary reason for your referral to see a Registered Dietitian:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Altered GI Function | <input type="checkbox"/> Fatty Liver * | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes * |
| <input type="checkbox"/> GERD | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Food allergy/intolerance | <input type="checkbox"/> Prediabetes* |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Liver cirrhosis | <input type="checkbox"/> Appetite concerns | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Inflammatory bowel disease | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Hypertension * |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Irritable bowel syndrome * | <input type="checkbox"/> Malnutrition | <input type="checkbox"/> Dyslipidemia * |
| <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Renal concerns |
| <input type="checkbox"/> Diverticular disease | <input type="checkbox"/> Celiac disease * | <input type="checkbox"/> Prenatal nutrition concerns | |
| <input type="checkbox"/> Short bowel | <input type="checkbox"/> Swallowing concerns/dysphagia | <input type="checkbox"/> Weight management* (circle if requires weight gain or loss) | |
| <input type="checkbox"/> Other (specify) _____ | | | |

* Nutrition Services Group Education classes

Your patient **will be required to attend a group education class** related to their nutritional concern prior to being eligible for nutrition counseling. If we do not offer a class specifically for their condition then they will be eligible to book directly into a nutrition counseling appointment with a registered dietitian.

Supervised Group Exercise Classes (Physician or health care provider and self-referral accepted)
Requirements

- Patient must be attached to a Family Physician or Nurse Practitioner
- Patient must have at least one chronic health condition
- Patient must be able to walk 5 metres
- Patient must be cognitively able to manage their own health condition
- 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.

Physicians or Nurse Practitioners:

This patient has been evaluated for risk of cardiovascular, pulmonary, and metabolic disease and is medically stable to proceed with exercise.

Physician Name (Last, First)

Physician Signature

Non-Physician Health Care Providers:

Your patient may be required to see their physician to obtain clearance prior to starting our exercise program.

Health Care Provider Name (Last, First)

Health Care Provider Signature

Health Conditions (please check all that apply to this patient)

- | | | | | | |
|---|--|--------------------------------------|---|--------------------------------------|-------------------------------------|
| Cardiovascular | Metabolic | Respiratory | Musculoskeletal | Neurological | Mental Health |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Dyslipidemia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> MS | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> CAD | <input type="checkbox"/> Fatty Liver | <input type="checkbox"/> COPD | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Depression |
| <input type="checkbox"/> MI | <input type="checkbox"/> Pre-Diabetes | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Parkinson's | |
| <input type="checkbox"/> CHF | <input type="checkbox"/> Obesity | | <input type="checkbox"/> Osteoporosis | | |
| <input type="checkbox"/> Electrical Abnormalities | <input type="checkbox"/> Diabetes Type 1 | | <input type="checkbox"/> Total Hip Replacement | | |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Diabetes Type 2 | | <input type="checkbox"/> Total Knee Replacement | | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Other chronic condition(s) not listed above | | | | |
| <input type="checkbox"/> Valve Disease | | | | | |