

Visit [ahs.ca/cdmcalgaryzone.asp](http://ahs.ca/cdmcalgaryzone.asp) for information on the Alberta Healthy Living Program.  
 For referral information visit [InformAlberta.ca](http://InformAlberta.ca) or [AlbertaReferralDirectory.ca](http://AlbertaReferralDirectory.ca).

**Important notes**

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 have your patients call 403 943 2584 (403 9HEALTH) to register.

**Note:** We accept self-referrals to the group exercise program, however, patients must be attached to a Family Physician or Nurse Practitioner. Please see criteria to attend the exercise program on page 2.

Physicians or Nurse Practitioners referring to exercise are asked to provide a signature clearing patients to exercise (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

**Please check all health conditions that apply to this patient**

- | <b>Cardiovascular</b>                             | <b>Metabolic</b>   | <b>Respiratory</b>                   | <b>Musculoskeletal</b>                          | <b>Neurological</b>                  | <b>Mental Health</b>                |
|---|--|--------------------------------------|---|--------------------------------------|-------------------------------------|
| <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            |  |                                      |   |                                      |                                     |