Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X) ☐ Unknown	

OT Services for Chronic Disease Management Referral

Please send the completed form by fax to

Primary Care Chronic Disease Management

Edmonton Zone Fax 780-643-1214 Phone 780-342-8302

Patient Information		
Date of referral *(dd-Mon-yyyy)*		
Last Name	First Name	
Gender	Date of Birth *(dd-Mon-yyyy)*	PHN
Street Address	City/Town	Postal Code
Home Phone Number	Cell Phone Number	Alternate Phone Number
Other Contact or Caregiver Name	☐ Please check if we should contact this person for booking	
What is the relationship to client?		

Referral Souce		
Name of person completing this referral	Designation	Contact Number
Fax Number	Clinic/Agency	
Client's Chronic Health Condition(s)		

Alberta Health Services

OT Services for Chronic Disease Management Referral

Our intervention is ***short term*** and our approach assesses the client's readiness for change.
The focus is driven from client goals aimed at empowering the client to engage in everyday life.

Please select the appropriate functional issue(s) below that you would like us to address.

Referral Souce Continued

- ☐ Confirm client/guardian is aware of this referral and agrees to initial assessment
- ☐ Client is NOT on Home Living, Supportive Living, or, Day Program to be eligible for services with our program.

Details for referral and special requirements *(i.e., need for service, language barrier, etc.)*

Difficulty in the Home

- ☐ Fall Prevention Assessment and Intervention
- ☐ Home modifications to enhance accessibility
- ☐ Provision of home safety equipment
  *(*equipment referrals only accepted in conjunction with at least one other area of assessment. For equipment-only referrals, please contact CCA)*
- ☐ Difficulty managing Activities of Daily Life *(Specify)* ______________________________

Difficulty getting in/out of the Home

- ☐ Home modifications to enhance accessibility
- ☐ Mobility assessment

Chronic Disease Self-Management Support

- ☐ Difficulty pacing *(managing energy/fatigue)*
- ☐ Difficulty managing sleep
- ☐ Difficulty maintaining physical activity
- ☐ Difficulty managing Instrumental Activities of Daily Life *(Specify)* ______________________________

Group Programming

- ☐ Boosting Your Brain Health
- ☐ Making the Most of Your Energy

Notes