

For clients seeking a referral **related to diabetes or adult weight management**, please complete the [Alberta Healthy Living Program Chronic Disease Referral](#) form.

For other reasons listed below use this form, and direct inquiries and referrals to appropriate locations:

**Brooks and Rural Area**
**Phone:** 1-403-793-6659

**Fax:** 1-403-501-3327

**Lethbridge and Rural Area**
**Phone:** 1-866-506-6654

**Fax:** 1-403-317-0435

**Medicine Hat and Rural Area**
**Phone:** 1-403-528-5628

**Fax:** 1-403-529-8005

**Client Demographics** *(Affix client label here if applicable)*

|                                                                                   |                      |                                    |
|-----------------------------------------------------------------------------------|----------------------|------------------------------------|
| <b>Client Height</b>                                                              | <b>Client Weight</b> | Date of Birth <i>(dd-mon-yyyy)</i> |
| First Name                                                                        |                      | Last Name                          |
| Address                                                                           |                      | Preferred Phone                    |
| Personal Health Care Number                                                       |                      | Alternate Phone                    |
| Family Physician                                                                  |                      | Referral Date <i>(dd-mon-yyyy)</i> |
| Interpretation required? <input type="checkbox"/> Yes <input type="checkbox"/> No |                      | Primary Language                   |
| Other communication needs                                                         |                      |                                    |
| Referral Source and Contact Phone                                                 |                      |                                    |

**General Program Information**

Patients may be required to attend a group education class before being booked for individual counselling. A referral from a physician or mental health professional is required for clients with eating disorders.

**Nutrition Group Education**

Patients can self-refer to nutrition education classes through our website [www.ahs.ca/nutritionworkshops](http://www.ahs.ca/nutritionworkshops)

**Reason for Referral**

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Allergies/Intolerance <i>(specify)</i> _____<br><input type="checkbox"/> Alcohol Associated Liver Disease (ALD)<br><input type="checkbox"/> ARFID<br><input type="checkbox"/> Celiac Disease<br><input type="checkbox"/> Disordered Eating <i>(specify)</i> _____<br>Confirmed Diagnosis <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Dyslipidemia<br><input type="checkbox"/> Feeding Difficulties - picky eating, texture progression, limited food choices, feeding issues <i>(specify)</i> _____<br><input type="checkbox"/> Gastrointestinal <i>(specify)</i> _____<br><input type="checkbox"/> General Nutrition <i>(specify)</i> _____ | <input type="checkbox"/> Hypertension<br><input type="checkbox"/> Inflammatory Bowel Disease (IBD)<br><input type="checkbox"/> Irritable Bowel Syndrome (IBS)<br><input type="checkbox"/> Malnutrition- unintentional weight loss/poor appetite<br><input type="checkbox"/> MASLD<br><input type="checkbox"/> Pediatric Weight Management<br><input type="checkbox"/> Pregnancy<br><input type="checkbox"/> Suboptimal Growth and Weight <i>(specify)</i> _____<br><input type="checkbox"/> Vitamin/Mineral Deficiency <i>(specify)</i> _____<br><input type="checkbox"/> Other _____ |
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**Please add any other relevant information pertaining to the reason for referral**