


Client Demographics (affix client label here if applicable)

Client Name		Date of Birth
Address		Home Phone
Personal Health Care Number		Cell Phone
Family Physician		Referral Date
Referral source and contact phone number		
Does the referred client have a legal guardian/agent? <input type="checkbox"/> No <input type="checkbox"/> Yes, name and contact phone number		
<input type="checkbox"/> Unable to participate in group education (describe)		
<input type="checkbox"/> Hearing or visual impairment (describe)		
<input type="checkbox"/> Mobility limitations (describe)		
<input type="checkbox"/> Unable to read or speak English	First language spoken is	
Translator name and contact phone number		

Specialty Services (check primary reason for referral)

<input type="checkbox"/> Asthma and Chronic Obstructive Pulmonary Disease (COPD) Program <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) <ul style="list-style-type: none"> Includes respiratory education, assessment and referral to exercise for COPD 		
<input type="checkbox"/> Better Choices, Better Health™ (Stanford self management series) <ul style="list-style-type: none"> Includes a 6 week workshop that helps you take control of your health 		
<input type="checkbox"/> Cardiac Rehabilitation • Includes cardiac education, assessment and referral to exercise		
<input type="checkbox"/> Diabetes <input type="checkbox"/> Impaired Fasting Glucose (IFG) and/or Impaired Glucose Tolerance (IGT) <input type="checkbox"/> Insulin Initiation and Adjustment. Physician orders attached. <input type="checkbox"/> New Pump Assessment <input type="checkbox"/> Existing Pump Therapy <input type="checkbox"/> Non-Insulin Medication(s) Initiation and Adjustment. Physician orders attached. <input type="checkbox"/> Pregnancy <input type="checkbox"/> Gestational <input type="checkbox"/> Type 1/ Type 2 <input type="checkbox"/> Preconception <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2		
<p>* If routine diabetes blood work is NOT completed at the time of referral, using the lab work protocol, the required blood work will be requisitioned and results sent directly to the referring and family physician for follow up care. This protocol will be followed as long as the client is under the care of specialty services.</p>		
<input type="checkbox"/> Heart Failure Network Education <input type="checkbox"/> Semi-urgent (less than 4 weeks) <input type="checkbox"/> Non-Urgent (less than 6 weeks)		
<input type="checkbox"/> Heart Function Clinic (Internal Medicine Consult with Interdisciplinary Services, <u>Physician Referral Required</u>) <input type="checkbox"/> Consult letter attached <input type="checkbox"/> Urgent (less than 2 weeks) <input type="checkbox"/> Semi-urgent (less than 4 weeks)		
<input type="checkbox"/> Nutrition	Client's Height	Client's Weight
Primary reason for referral:		
<input type="checkbox"/> Healthy Weight Gain in Pregnancy		
<input type="checkbox"/> Risk Factor Management <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Hypertension <input type="checkbox"/> Risk Reduction Class		
<input type="checkbox"/> Stroke/Transient Ischemic Attack (TIA) Education		
<input type="checkbox"/> Supervised Exercise <u>Physician Signature Required:</u> <input type="checkbox"/> Pre-requisite form was given to client		
<input type="checkbox"/> Weight Management		
Comments		
Office Use Only		
<input type="checkbox"/> Appointment scheduled on		

* Fax completed form to 403.317.0435. For further questions, call AHLP 403.388.6654 or 1.866.506.6654