Alberta Health Services

Alberta Healthy Living Program
Chronic Disease Referral South West Zone

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? ☐ No ☐ Yes, name and contact phone number	
☐ Unable to participate in group education *(describe)*	
☐ Hearing or visual impairment *(describe)*	
☐ Mobility limitations *(describe)*	
☐ Unable to read or speak English	First language spoken is
Translator name and contact phone number	

Specialty Services ***(check primary reason for referral)***

☐ **Asthma and Chronic Obstructive Pulmonary Disease (COPD) Program**
- ☐ Asthma ☐ Chronic Obstructive Pulmonary Disease (COPD)
- Includes respiratory education, assessment and referral to exercise for COPD

☐ **Better Choices, Better Health™ (Stanford self management series)**
- Includes a 6 week workshop that helps you take control of your health

☐ **Cardiac Rehabilitation** • Includes cardiac education, assessment and referral to exercise

☐ **Diabetes**
- ☐ Impaired Fasting Glucose (IFG) and/or Impaired Glucose Tolerance (IGT)
- ☐ Insulin Initiation and Adjustment. Physician orders attached.
- ☐ New Pump Assessment ☐ Existing Pump Therapy
- ☐ Non-Insulin Medication(s) Initiation and Adjustment. Physician orders attached.
- ☐ Pregnancy ☐ Gestational ☐ Type 1/ Type 2 ☐ Preconception
- ☐ Type 1 ☐ Type 2

* 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.

☐ **Heart Failure Network Education** ☐ Semi-urgent (less than 4 weeks) ☐ Non-Urgent (less than 6 weeks)

☐ **Heart Function Clinic (Internal Medicine Consult with Interdisciplinary Services, <u>Physician Referral Required</u>)**
- ☐ Consult letter attached
- ☐ Urgent (less than 2 weeks)
- ☐ Semi-urgent (less than 4 weeks)

☐ **Nutrition**	Client's Height	Client's Weight
Primary reason for referral:		
☐ Healthy Weight Gain in Pregnancy		

☐ **Risk Factor Management** ☐ Dyslipidemia ☐ Hypertension ☐ Risk Reduction Class

☐ **Stroke/Transient Ischemic Attack (TIA) Education**

☐ **Supervised Exercise <u>Physician Signature Required:</u>** _____
- ☐ Pre-requisite form was given to client

☐ **Weight Management**

Comments

Office Use Only	☐ Appointment scheduled on

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