Chronic Disease Management Referral Form

Primary Care Network
SHERWOOD PARK
STRATHCONA COUNTY

108, 150 Broadway Crescent Sherwood
Park AB T8H 0V3
Tel: (780) 410-8000 Fax: (780) 416-0139

Parent/Guardian/Caregiver: ☐

Phone Number: ☐

Patient Label

Is patient aware of referral? ☐ **Yes** ☐ **No**

MEDICAL HISTORY:
EMR Attached? ☐ **Yes** ☐ **No**
(If no, please check all that apply):

- ☐ Prediabetes/IFG/IGT
- ☐ Diabetes
  - ☐ Type 1
  - ☐ Type 2
- ☐ Obesity/Overweight
- ☐ Hypertension
- ☐ Dyslipidemia
- ☐ Arthritis/MSK Issues
- ☐ Tobacco Use
- ☐ Heart Disease
- ☐ Asthma/COPD
- ☐ Mental Health Diagnosis ☐
- ☐ Other ☐

REASON FOR REFERRAL:
Please see website for CHANGE Program and Diabetes Program details: www.sherwoodparkpcn.com

☐ CHANGE Program (Canadian Health Advanced by Nutrition and Graded Exercise)	☐ *Lipid panel, fasting glucose, A1C within 6 months ☐ Attach list of current medications
☐ Diabetes Program	☐ *A1C within 6 months ☐ Attach list of current medications ☐ # hypos/week: ☐
☐ Medication Review	☐ Attach list of current medications
☐ Special Dietary Consult (eg. IBS, IBD, Celiac, Pediatric, Underweight)	List Dietary Concern(s): ☐
☐ Special Exercise Consult	List Activity Restriction(s): ☐
☐ Tobacco Reduction	

ADDITIONAL INFORMATION:

Visit www.sherwoodparkpcn.com for info on our programs and healthy living classes (no referral required for classes).

PHYSICIAN INFORMATION:

***Your signature on this referral confirms your agreement to have PCN clinicians order labs under your Prac ID for follow-up lab work as per program guidelines.**

Referring Physician: ☐ Clinic Name: ☐

Referral Date: ☐ Phone: ☐

Physician SIGNATURE: _____ Fax: ☐

PATIENT'S REGULAR FAMILY PHYSICIAN *if different than referral physician:* _____