Primary Care Network GRANDE PRAIRIE

Fax completed form to: 587-259-9774

ACCESSING YOUR PCN CENTRAL TEAM

For more detailed information on our services please visit:
https://grandeprairiepcn.com/programslanding/memberclinicinfo/

REFERRAL INFORMATION

Date of Referral: MM/DD/YYYY	Physician/NP: Prac ID:	*(If Applicable)* *Locum for*:
Provider Phone:	Clinic/Facility:	

PATIENT INFORMATION

First Name:	Middle Name(s):	Last Name:	
DoB*: DD/MM/YYYY *See age restrictions under each service	Sex: ☐ Female ☐ Male	Other:	
Email address:	Cell Phone:	Home Phone:	PHN:
Address:	City:	Prov:	Post Code:

(*If Applicable*) Authorized Representative's Name: ☐ Legal Guardian ☐ Trustee ☐ Enacted Personal Directive Agent

SELECT SERVICES REQUIRED

Allergy Clinic *Age 6 and over

Exclusions: Previous anaphylaxis, testing for bee sting and medication allergies

☐ Allergy testing ☐ Follow-up

Suspected Diagnosis:
☐ Asthma ☐ Continuous URI
☐ Rhino Conjunctivitis/Sinusitis ☐ Food Allergy
☐ Environmental Allergy

Has the patient ever been prescribed a puffer/inhaler for asthma? ☐ Yes ☐ No

Is the patient currently on Beta-blockers?
☐ Yes ☐ No

Diabetic Retinopathy Screening Clinic (DRSC) *Age 18 and over

Exclusions: Gestational diabetes

☐ Eye testing/screening

Dietitian *Age 14 and over

Exclusions: Active eating disorder, newly diagnosed Type 1 Diabetes

☐ Allergies / Intolerance / Celiac disease
☐ Cardiovascular disease ☐ Diabetes / pre-diabetes
☐ Digestive symptoms (diarrhea, constipation)
☐ Healthy Eating ☐ Hepatic disorders (fatty liver)
☐ IBD (Crohn's, colitis) ☐ IBS
☐ Mindful eating / food relationship ☐ Prenatal / postnatal
☐ Other: Specify in 'other information' below

Exercise Therapy *Age 14 & over & GLA:D® Program *Age 18 & over

Selecting one of the below indicates that patient is cleared for unrestricted exercise or physical activity unless you click here ☐ and provide details including restrictions, in 'other information' below.

☐ Cardiovascular Disease ☐ Deconditioning/sedentary
☐ Diabetes (includes Prediabetes) ☐ Exercise instruction (strength, mobility, balance, coordination) ☐ Joint pain/stiffness
☐ Mental Health- Exercise for MH ☐ Osteoporosis/Osteopenia
☐ Prenatal / Postnatal
☐ Other: Specify in 'other information' below

GLA:D® Program
☐ 8 week, 2x/week, supervised exercise program for Knee/Hip OA

Mental Health *Age 14 and over

Exclusions: Couples therapy, Acute MH & Addictions concerns

Risk assessment for acute mental health: **Suicidal/Homicidal/Psychosis** refer directly to Emergency or call 911 to activate PACT TEAM. **In-person risk assessment available in Grande Prairie via** ICAT 587-259-5513. Severe mental health and substance abuse concerns refer to Access Addictions and Mental 1-88-594-0211.

☐ Adjustment disorder ☐ Anxiety/stress ☐ Depression ☐ Grief/Loss ☐ Interpersonal issues (e.g relationships)
☐ Other: Specify in 'other information' box (below)

Mental Health Requirements:

☐ **PHQ-9** reviewed & attached. **SCORE:** ____

☐ **GAD-7** reviewed & attached. **SCORE:** ____

Persistent Pain Services

*Age 18 and over

Exclusions: Pain less than 3mths, active WCB claim, active addiction, prescription management including opioids

Please specify CONFIRMED DIAGNOSIS(ES) in the box below.

Requested Service(s):
Check all that apply below.

☐ Self-management support through a behavioural health approach
☐ Trigger point injections ☐ Botox
☐ Medication review/suggestions
☐ Pain Specialist/NP consultation, specify reason in 'other information' below

Social Work *Age 14 and over

Exclusions: Legal advice, Office of the Public Guardian, WCB

☐ Helping with government program applications (e.g. CPP, OAS, AISH, Income Support, DTC, student aid, health benefits)
☐ Financial/food security ☐ Housing resources
☐ Navigation & self-management skills
☐ Other: Specify in 'other information' below

We also offer several classes and workshops that patients can access directly. Details can be found at:
http://grandeprairiepcn.com/groups/

PLEASE PROVIDE ALL OF THE FOLLOWING:

MEDICAL AND SOCIAL HISTORY: Attached? ☐ Yes ☐ No **If not attached, please provide a written summary**.
Include relevant consultant letters, specialist referrals, discharge summaries, diagnostic reports, and previous programming if not available on Netcare.

CONFIRMED DIAGNOSIS(ES):

MEDICATIONS: ☐ Yes ☐ No **List attached?** ☐ Yes ☐ No
If not available on Netcare and not attached, please list type, dosage, and frequency details:

OTHER INFORMATION:

To avoid having this form returned, or referral delayed, please ensure ALL provider and patient information is completed.