ESPCN MULTIDISCIPLINARY TEAM REFERRAL FORM

Patient Contact Information (please print or attach label)

Last Name: _____ Email: _____

First Name: _____ Full Address: _____

PHN: _____ _____ Postal Code: _____

DOB (*mm/dd/yyyy*): _____ Gender: _____ Translation Required: ☐ Yes ☐ No

Ph. No.: _____ Cell No.: _____ If yes, language: _____

REASON FOR REFERRAL / ADDITIONAL RELEVANT INFORMATION

To avoid your referral being declined, please attach all applicable documentation (e.g.: medications lists, cognitive screens, all relevant diagnostics, etc.)

REFERRAL TYPE

Referral-Based Programs

☐ **Breathing for Health** *(Pulmonary Rehab)*
Include: ☐ ECG (within 6 mos)
☐ PFT or Spirometry (within 6 mos)
☐ CXR (within 12 mos)

☐ **GLA:D™ Canada** *(Group-based Education & Exercise Program)*
☐ Hip OA or Knee OA
☐ Back (chronic low back pain, no red flags)

☐ **Lower Leg Assessment Clinic**
☐ Must complete page 2 of the Referral Form

☐ **Moving for Memory** *(Mild Cognitive Impairement)*
Include: ☐ Cognitive screens (within 12 mos)

☐ **Psych Linkages**
One-time consult for diagnosis and treatment recommendations for adults 18-65 years old.
Include: ☐ Referral letter

Refer ONLY if you do not have these services in your clinic:

☐ **Behavioural Health Consultant**

☐ **Exercise Specialist**

☐ **Primary Care Registered Nurse**

☐ **Registered Dietitian Services**

☐ **Respiratory Therapist Services**

☐ **Social Worker (All Ages)**

Please visit *www.espcn.ca/workshops* for additional patient self-referral supports, including **Seniors' Centre Without Walls**

PHYSICIAN / MULTIDISCIPLINARY TEAM INFORMATION (Please Print)

Referring Physician: _____ Clinic: _____

Date of Referral: _____ Referred By (if different from above): _____

Phone: _____ Fax: _____

Primary Care Network EDMONTON SOUTHSIDE

Fax Referral to 780.435.5526

Edmonton Southside Primary Care Network
3110 Calgary Trail NW, Edmonton, AB T6J 6V4
P: 780.395.2626 F: 780.435.5526
edmontonsouthsidepcn.ca

ESPCN LOWER LEG ASSESSMENT CLINIC REFERRAL FORM

Patient Contact Information (please print or attach label)

Name: _____

PHN: _____

DOB: _____ Gender: _____

Patient currently receiving Homecare services: ☐ Yes ☐ No

EXCLUSION CRITERIA:

1. **Homebound patients receiving Homecare services**
   (Please refer back to Homecare for lower leg edema or wound management)
2. **Patients who cannot transfer independently or lie flat for assessment**

PATIENTS MUST COMPLETE THE FOLLOWING TESTS PRIOR TO BEING SEEN AT THE CLINIC

☐ **ALL PATIENTS**: ABI **with toe pressures** (within 1 year)

☐ **WOUNDS only** (within 2 weeks of referral): CBC & diff, CRP, wound swab

THE FOLLOWING MUST ACCOMPANY THE REFERRAL

PATIENT MEDICAL HISTORY

☐ EMR summary that includes:

- ☐ Past Medical History

CURRENT MEDICATION (Please Attach List)

☐ All current medications

REASON FOR REFERRAL

☐ HIGH RISK FOOT

Please specify:

- ☐ Callus/pressure area
- ☐ Foot deformity

☐ LOWER LEG EDEMA

Currently wears compression stockings:

☐ Yes ☐ No

☐ WOUNDS

Wound location: _____

Has patient been treated at a wound clinic?

☐ No ☐ Yes, where: _____

ADDITIONAL INFORMATION

Primary Care Network
EDMONTON SOUTHSIDE

Fax Referral to 780.435.5526

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