

PLEASE COMPLETE ALL SECTIONS

Main Reason for Referral:	Date of Referral: (dd/month/yyyy)
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Medical History **Consult Note** **Medications** **Current lab results** **I have discussed referral with individual**

Name of Referring Individual	Phone	Fax	Profession
Name of Patient's Family Physician	Phone	Fax	

Patient Profile

Surname	Given Name
PHN	DOB dd/mmm/yy <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> other
Address Include Postal Code	
Primary Phone#	Secondary Phone#
Email:	
<input type="checkbox"/> Patient may benefit from programs that focus on First Nations, Métis or new immigrants	
Suitable for Group? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other considerations: <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Language - Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Impaired Mobility <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Mental Health <input type="checkbox"/> Low Income <input type="checkbox"/> Transportation <input type="checkbox"/> Other:	

Adult Nutrition	Cardiovascular	Chronic Disease Self Management Workshops
<input type="checkbox"/> Celiac <input type="checkbox"/> IBD <input type="checkbox"/> IBS <input type="checkbox"/> Heart Healthy Nutrition (Group) <input type="checkbox"/> Weight Management Group <input type="checkbox"/> Other: _____	<input type="checkbox"/> Cardiac Rehabilitation Education	<input type="checkbox"/> LiveWell with Chronic Conditions <input type="checkbox"/> LiveWell with Chronic Pain

Diabetes

By referring to the Diabetes Program, you consent to short term insulin adjustment by the Nurse Clinician using 1-2 units/up to 10% of daily dose (as per Saskatoon and Area CDM Insulin Dose Adjustment policy and medical directive). The nurse will connect with MRP if concerns.

I do not consent to the diabetes nurse clinician adjusting insulin.

New Diagnosis Pre-existing Type 1 Type 2 Pre-diabetes Other

Adult <input type="checkbox"/> Education with referral to Diabetes Specialist by Clinician if needed <input type="checkbox"/> Diabetes Specialist Physician & Multidisciplinary team (Physician Referral Required)	Pregnancy (attach pre-natal sheet) <input type="checkbox"/> Gestational <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 EDC: _____	Pediatric Age 0-16, undiagnosed type 1 and type 2 (Age 17-18, consider adult referral) Newly diagnosed, untreated diabetes considered urgent - consult pediatric endocrinology at RUH at 306-655-1000 Non-urgent referrals – Fax: 306-844-1536 Ph: 306-655-2048
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Exercise	Pediatric Obesity	Respiratory	Rheumatology
<input type="checkbox"/> Cardiac <input type="checkbox"/> Pre-Diabetes <input type="checkbox"/> Diabetes <input type="checkbox"/> Parkinson's <input type="checkbox"/> Stroke <input type="checkbox"/> Pulmonary <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> Other: _____	Pediatric (include growth chart) <input type="checkbox"/> Multidisciplinary Clinic <input type="checkbox"/> Dietitian only	<input type="checkbox"/> COPD Nurse <input type="checkbox"/> Asthma Nurse (attach spirometry /PFT)	(check all that apply) <input type="checkbox"/> OA <input type="checkbox"/> RA <input type="checkbox"/> AS <input type="checkbox"/> Lupus <input type="checkbox"/> Reactive Arthritis <input type="checkbox"/> Polymyalgia <input type="checkbox"/> Psoriatic Arthritis Other: _____

Comments: