ESPCN MULTIDISCIPLINARY TEAM REFERRAL FORM

Patient Contact Information (please print or attach label)

Name: _____

PHN: _____

DOB: _____ Gender: _____

Is it ok to leave a telephone message? ☐ Yes ☐ No

Ph. No.: _____ Cell No.: _____

Full Address: _____

_____ Postal Code: _____

Alternate Contact:

Name: _____

Ph. No.: _____

REFERRAL TEAM

ALL CLINICS:

☐ **Breathing for Health - Pulmonary Rehab***
Include ECG (within 6 mos), PFT (within 6 mos) and CXR (within 12 mos).

☐ **Central Social Worker - All Ages**
Practical supports beyond what the BHC role provides.
Following criteria **only**:
- ☐ Personal Directives / Enduring Power of Attorney documents
- ☐ Financial and health benefits
- ☐ Subsidized housing, supportive living, and emergency shelters
- ☐ Capacity assessments for Guardianship or Trusteeship only (consult letter required)

☐ **GLA:D™ Canada Hip & Knee - Exercise Rehab**
X-ray confirmed ☐ Hip or ☐ Knee OA

☐ **Lower Leg Assessment Clinic** - **Page 2 of referral form must be completed**

☐ **Moving for Memory***
Include recent cog screens

* May be on hold or alternate format due to COVID-19

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

☐ **Behavioural Health Consultant**

☐ **Primary Care Nurse**
Specify needs below: chronic disease management, healthy aging, home visit, prenatal teaching, lifestyle

☐ **Dietitian**

☐ **Exercise Specialist**

☐ **Respiratory Therapist / Educator**
Support patient to manage: Asthma, COPD, ILD, Home O_2, Sleep Apnea, Tobacco Cessation, Spirometry

☐ **Psychiatrist Linkages** NEW
Single consult for diagnosis and treatment recommendations for adults 18-65 years old. Consult letter required.

Please see Workshops tear pad for additional patient self-referral supports, including **Seniors' Centre Without Walls**

REASON FOR REFERRAL

PHYSICIAN/MULTIDISCIPLINARY TEAM INFORMATION (Please Print)

Family Physician: _____ Clinic: _____

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

Phone: _____ Fax: _____

Fax Referral to 780.435.5526

Please attach all applicable documentation eg: med list, cog screens, all relevant diagnostics, etc.

Primary Care Network
EDMONTON SOUTHSIDE

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: _____

Receives Homecare ☐ No ☐ Yes

EXCLUSION CRITERIA:

1. **Patients Receiving Homecare** (Please refer back to Homecare for lower leg edema or wounds)
2. **Patients that cannot transfer independently or lie flat for assessment**
3. **Stage 4 Ulcers** = Full thickness tissue loss with extensive destruction/necrosis or visible muscle/bone (Please refer to specialty wound clinic)

REASON FOR REFERRAL

☐ HIGH RISK FOOT*

Please specify:

- ☐ Callus
- ☐ Redness/pressure area
- ☐ Loss of sensation

* Re-refer patients seen >1 year ago (ABI/TBI required)

☐ LOWER LEG EDEMA

Currently wears compression stockings: ☐ No ☐ Yes

Symptoms of claudication present: ☐ No ☐ Yes

☐ WOUNDS (Lower Leg / Foot Wounds Only)

Please specify STAGE:

- ☐ **Stage 1:** Persistent redness/pressure area with intact skin and or erythema/bogginess.
- ☐ **Stage 2:** Partial thickness loss of skin involving epidermis/dermis. Abrasion, blister or shallow crater.
- ☐ **Stage 3:** Full thickness tissue loss up to fascia. Deep crater without undermining.

Wound location: _____

Has patient been treated at a wound clinic?

☐ No ☐ Yes, where: _____

☐ Podiatrist: _____

PATIENT MEDICAL HISTORY

☐ Cancer (please specify): _____

☐ Diabetes† ☐ Heart Failure EF%: _____ ☐ Hypertension

☐ Obesity ☐ Peripheral Arterial Disease

☐ Recent Surgeries (please specify): _____

CURRENT MEDICATION (Please Attach List)

Taking any of the following:

☐ Anticoagulants/antiplatelets ☐ Cytotoxic agents ☐ NSAIDs ☐ Steroids

PLEASE SEND PATIENT FOR FOLLOWING TESTS PRIOR TO BEING SEEN AT THE CLINIC

- **ALL PATIENTS:** ABI **with toe pressures** (within 6 months of referral)
- **WOUNDS only:** CBC & diff, CRP (within 2 weeks of referral); A1C (within 90 days of referral)
- **CHARCOT FOOT only:** x-ray foot AP & Lateral (within 6 months of referral)

† Diabetes foot care clinical pathway: https://www.albertahealthservices.ca/scns/Page10321.aspx;
Diabetes foot screening tool: https://www.albertahealthservices.ca/frm-20710.pdf

Fax Referral to 780.435.5526