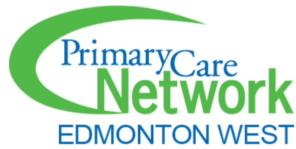


#124 Meadowlark Health and Shopping Centre
156 Street and 87 Ave, Edmonton, AB T5R 5W9
Phone: 780-443-7477 **Fax:** 780-481-9149
Website: www.edmontonwestpcn.com

The EWPCN has updated our Main Referral Form. Updates to the referral form have been made to align with our vision of "providing the best primary care to our community".

A separate Frail Elderly Form has been created in addition to our Main Referral Form.

The updated forms will improve clinician assessments and care by identifying patient root causes and barriers to success in achievement of health goals.

Main Referral Form

#124, Meadowl[illegible]alth and Shopping Centre, 156 Street & 87 Avenue, Edmonton, AB T5R5W9

EWPCN [illegible] Referral Form

Date of Referral:	*For urgent referrals please call 780-443-7477*	
Patient information: Full Name: PHN: DOB: Gender: Address: Phone Number: Alternate Phone Number:	**Referring Provider** *(Include Prac Id)*: **Clinic:**	**Family Physician:** **EWPCN Clinician Name:**
	Special Requirements: ☐ Needs Translator ☐ Hearing Impairment	☐ Language Barrier ☐ Visual Impairment ☐ Other: ____________
	BP: **Weight:**	**Height:** **BMI:**

MANDATORY - Reason for Referral: *(Please attach pertinent labs results, clinical notes/ patient summary sheet, and a recent medication list)*

To help us better understand the needs of your patient, check all applicable concerns:

Mental:	Mechanical:	Metabolic:	Monetary:
☐ Addiction	☐ Breathing Problems	☐ Cancer	☐ Finances
☐ Anxiety	☐ Gastrointestinal Issues	☐ Cardiovascular	☐ Employment
☐ Attention Deficit	☐ Inactivity	☐ Heart Disease	☐ Accommodation
☐ Depression	☐ Activity Restrictions	☐ Dyslipidemia	☐ Food
☐ Grief / Loss	Explain: ____________	☐ Hypertension	☐ Medical Supplies
☐ Trauma	☐ Mobility Issues	☐ Stroke	☐ Medications
☐ Disordered Eating	☐ Pain	☐ Diabetes	☐ Transportation
☐ Emotional Eating	☐ Chronic	☐ Hypothyroid	☐ Social Isolation
☐ Poor Body Image	☐ Acute	☐ Liver Disease	☐ Community Resources
☐ Sleep Disturbance	☐ Sleep Disorders	☐ Medication Concerns	☐ Other: ____________
☐ Stress	☐ Other: ____________	☐ Smoking	☐ Guardian/Trustee ONLY
☐ Cognitive Concerns		☐ Other: ____________	*(*Capacity Assessment – Please attach referral forms*)*
☐ Other: ____________			☐ Personal Directive

Select below which discipline(s) your patient would like to see:

☐ **Behavioural Health Consultant**	☐ **Psychiatrist** **Letter required**	☐ **Low Risk Maternity Clinic**
☐ **Exercise Specialist**	☐ **Registered Dietitian**	**Gravida:** ____________
☐ **Pharmacist**	☐ **Social Worker**	**Para:** ____________
		EDC by LMP: ____________

If more than one discipline is selected, patients will be consulted to determine which discipline they will see first.

Please consider that your patient's needs may be met with EWPCN Workshops
(See green tear off workshop sheet or visit www.ewpcn.com).

Booking line 780-443-7477 | Fax completed form to 780-481-9149

This facsimile contains confidential information intended for the person to whom it is addressed. Any other distribution, copying, or disclosure is strictly prohibited by law. If you have received this facsimile in error, please inform the sender immediately by phone and then destroy the original without making a copy.

Final March 2019

Referring provider section: "*Include Prac ID:*" this is required for psychiatric consultation and maternity clinic referrals for billing purposes.

Special Requirement section: This is more specific than the previous referral form and is integral to having a successful appointment. Example: If a patient requires a translator, this can be arranged prior to the appointment date.

4 M's section: As clinicians who see patients in the central office do not have access to clinic EMR's, this additional information is helpful in enabling them to provide a more focused and patient-centered appointment. It also may identify a need for additional team-based care for the patient. Completion of the 4M's section prior to requesting referral to specific discipline(s), is meant to encourage the referring provider to consider the patient's overall health status and have a collaborative discussion with the patient to determine what disciplines the patient would like to have involved in their care.

Discipline Selection section: If multiple disciplines have been selected on the referral form, patients will be consulted at time of appointment booking to see who they would like to see first. If they choose to book with more than one discipline at time of booking, that will be permitted. If they choose to start with one discipline, leaving additional checked off disciplines on the referral form, the clinician that the patient sees first will be able to refer to the referral form to discuss other team members that were initially selected to be part of the patient's care. Patients can book with selected disciplines when ready. As per EWPCN current practice, when it is identified that an additional interdisciplinary team member would benefit the patient's care, an internal referral can continue to be made.

#124, Meadowlark Health and Shopping Centre, 156 Street & 87 Avenue,
Edmonton, AB T5R5W9

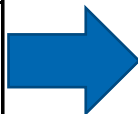
Frail Elderly Outreach Referral Form

Date of Referral:	**Does the Physician do Home Visits:** ☐ Yes ☐ No	
Patient information: Full Name: PHN: DOB: Gender: Address: Phone Number: Alternate Phone Number:	**Referring Provider:**	**Family Physician:**
	Clinic:	**EWPCN Clinician Name:**
	Special Requirements: ☐ Needs Translator ☐ Hearing Impairment	☐ Language Barrier ☐ Visual Impairment ☐ Other: _______________
	BP: **Weight:**	**Height:** **BMI:**

Is patient able to book own appointments: ☐ Yes ☐ No If no who is the contact person: ___________________

** This team is intervention based. If you prefer recommendations only, please specify. **

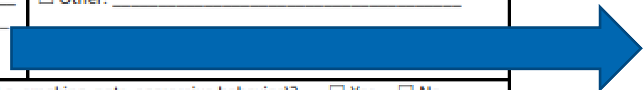
MANDATORY - Reason for Referral: *(Please attach pertinent labs results, clinical notes/ patient summary sheet, and a recent medication list)*



Check all that apply:

☐ ADL/ IADL Impairment	☐ Functional Assessment
☐ Change in Attention/LOC/Behavior	☐ Homebound
☐ Bowel/ Bladder Concerns	☐ Medically Complex
☐ Caregiver Stress/ Lack of Caregiver	☐ Nutritional Concerns/ Unexplained Weight Changes
☐ Cognitive Decline	☐ Pain
☐ Depressive Symptoms	☐ Polypharmacy
☐ Frequent Clinic / ED/ Acute Care Visits	☐ Recent Falls/ Mobility Concerns
	☐ Sleep Concerns

Other Involvement:	**Special Requirements:**
☐ Homecare Involvement _____________________	☐ Needs Translator, Language: __________________
☐ Recent Geriatric Assessment Completed	☐ Severe Hearing or Visual Impairment
Date: ______________ Location: ______________	☐ Other: ____________________________________
☐ Recent Admission(s) ______________________	
☐ Supportive Living	
☐ Other: ____________________________	



Are there any safety/ health concerns for a home visit (I.e. smoking, pets, aggressive behavior)? ☐ Yes ☐ No
Please Specify: ______________________________

Other Concerns: *(Please attach recent cognitive testing, recent specialist report, pertinent labs results, clinical notes/ patient summary sheet, and a recent medication list, not available on Netcare)*

Booking line 780-443-7477 | Fax completed form to 780-481-9149

This facsimile contains confidential information intended for the person to whom it is addressed. Any other distribution, copying, or disclosure is strictly prohibited by law. If you have received this facsimile in error, please inform the sender immediately by phone and then destroy the original without making a copy.

Final March 2019

The EWPCN has created a separate referral form for the Frail Elderly Program.
The form provides more detailed information which allows for triaging to the most appropriate resource on the Frail Elderly Team; NP, OT, Pharmacist, or BHC.

Other involvement: For enhanced coordination of care, Homecare, PT and RT may be considered. Furthermore, any volunteers for the patient would be beneficial to know. Any recent admission to secondary care for example ER, acute Care, or sub-acute.

It is your responsibility to ensure all your clinic staff including clinic managers, MOA's referral clerks and physicians are aware of this change and how to fill out the new referral forms. Physicians have been made aware of the new referral form in the physician newsletter. They are aware you will be meeting with them about these new referral forms.

Please ensure that all outdated referral forms are removed from treatment rooms and other places that paper copies may have been kept and used in your clinics.

As EMR's differ in the process and length of time it may take to upload the new referral forms, we appreciate the help of the Medical Home Team and your patience in transitioning to the new referral forms. An email to the clinic will be sent once the referral forms are successfully added to the EMR.

If the central office receives outdated referral forms, EWPCN front office staff will accept the referral but a fax will be sent to the clinic requesting that they use the new referral form and ensure it is up loaded in their EMR and marked as Clinic Favorite.

Diane and Jennifer will be visiting the clinics that do not have any resource to provide them with the new referral forms. The clinic manager will be instructed to contact Medical Home if assistance is needed in getting the new forms loaded in their EMR.