

CHANGE Program Letter of Commitment

Welcome to the Sherwood Park PCN Canadian Health Advanced by Nutrition and Graded Exercise (CHANGE) program.

CHANGE is a 12-month program that helps you to learn how to incorporate healthy eating, and physical activity into your lifestyle.

The CHANGE program offers an initial assessment, and weekly sessions in the first three months, and then monthly session for the next 9 months. Each session is two hours, with one hour of physical activity with the exercise physiologist, and one hour of healthy eating discussion with the registered nurse/dietitian.

The completion of follow-up lab work (blood sugars and cholesterol) at the 3rd and 12th month of the program are required. A health care provider will send a letter to your family physician to notify him/her of your progress and goals.

Research has demonstrated that regular follow up and goal setting is important in managing chronic conditions. We require that participants of the CHANGE program attend at least 75% of the sessions (approximately 16 sessions). We understand that events beyond your control can interfere with your intentions and plans. Together with a health care provider, you will determine if the Sherwood Park PCN CHANGE program will meet your health needs at this time.

Attendance at follow up appointments is expected, and appointments may be cancelled by calling the PCN within 48 hours' notice. Patients will be discharged from the program after two missed appointments (no show), or after three consecutive cancelled appointments.

Notification of the discharge will be sent to your family physician. It is the expectation of the CHANGE program that phone calls from your health care provider be returned within one week, and a health care provider will also return phone calls to you within one week.

Please sign the attached page to indicate your commitment to participate in the PCN CHANGE program.

Sincerely,

Sherwood Park Primary Care CHANGE Team

I wish to participate in the Sherwood Park PCN CHANGE program and understand and agree to the terms outlined in the CHANGE Program Letter of Commitment.

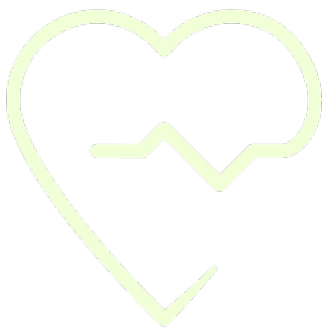
Name (please print) _____

Signature _____

Health Care Provider (print name) _____

Signature _____

Date _____



CHANGE
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