Primary Care Network
SHERWOOD PARK – STRATHCONA COUNTY

PCN
MCC Referral/Consult Form

Name of Parent/Spouse/Caregiver:_____

Phone for Parent/Spouse/Caregiver:_____

Is Patient Aware of Referral? Yes □ No □

Are phone messages appropriate? Yes □No □

Community Agencies Involved: (i.e. Home Care, Day Program, Mental Health, etc.)

Home Care Contact Name:_____Phone_____

REASON FOR CONSULT

Complete alternate forms for referring to: Geriatric Clinic, PCN Specialty Clinics (telederm, cardiology, general surgery), and specialist referrals.

PLEASE SELECT ALL THAT APPLY:

□ Arthritis/Mobility
□ CHF
□ Coronary artery disease

Diabetes
- □ pre diabetes/IGT-IFG
- □ newly diagnosed □ existing diabetic
- □ insulin start /adjustments(s)
- □ Other_____

□ Dyslipidemia
□ Hypertension
□ Medication review
□ Nutritional concerns regarding
_____

□ Obesity / Weight Management
- □ Adults
- □ Pediatrics (ages 2-17)

□ Tobacco Reduction (at Health First Strathcona)
□ Pain Clinic

RELEVANT HISTORY AND DETAILS

□ Consult
□ Treatment

Physician Information

Referred by **(PLEASE PRINT)**: _____ Date of Referral: _____

Clinic Name: _____ Physician SIGNATURE:_____

Phone: _____ Fax: _____

PATIENT'S REGULAR FAMILY PHYSICIAN *if different than referral physician*_____

Referral Requirements:

□ Attach all lab, x-ray and test results **if not available on Netcare**
□ Attach complete list of current medications
□ Attach pertinent patient Hx (EMR print out if available)
□ Can patient participate in an exercise program? Yes □ No □ Stress Test Required first? Yes □ No □