Multidisciplinary Care Clinic (MCC) Referral/Consult Form

Primary Care Network
SHERWOOD PARK
STRATHCONA COUNTY

If patient is under the age of 18, please include parent/guardian name and phone number

Clear Form

Patient Name:			PHN		
Address			City	Sherwood Park	Postal Code
Primary Phone #	Secondary Phone #	Cell/Alternate #	Date of Birth / /		Gender
Parent/Caregiver:	Phone # of Caregiver:		Comments:		

Reason For Referral/Consult

Patient aware of this referral:

Please select all that apply:

- ☐ Arthritis/Mobility
- ☐ CHF
- ☐ Coronary artery disease
- ☐ Diabetes
  - ☐ Pre-diabetes/IGT-IFG
  - ☐ Newly diagnosed
  - ☐ Existing diabetic
  - ☐ Insulin start/adjustment
  - ☐ Other _____
- ☐ Dyslipidemia
- ☐ Hypertension
- ☐ Medication review
- ☐ Nutritional concerns regarding _____
- ☐ Obesity / Weight Management
  - ☐ Adult
  - ☐ Pediatrics (2-17)
- ☐ Tobacco Reduction
- ☐ Pain Clinic

History & Referral Specifics

PHYSICIAN INFORMATION

Referred by: Date of Referral: Phone:

Fax: 780-416-0139 Physician Signature/Approval: _____

Sherwood Park Primary Care Network, 150 Broadway Crescent, Sherwood Park, AB T8H 0V3 Fax: (780) 416-0139

APPOINTMENT DATE & TIME: _____

Submit to PCN

Updated – November 2014