Primary Care Network
CAMROSE

CAMROSE | BASHAW | DAYSLAND
FORESTBURG | HARDISTY

Last Name _____ **First Name** _____
PIN _____ **Gender** _____
Address _____
_____
DOB _____ **Home Phone** _____
Work Phone _____ **Cell** _____

CDM Referral Form

Phone: 780.608.4927
Fax: 780.608.4931

Date of Referral _____Referral Physician _____

Family Physician _____ Phone _____ Fax _____

Date of next follow-up appointment with Physician (if any) _____
_____

Please complete referral(s) for:

□ Risk Reduction Program for
- □ Atrial Fibrillation
- □ COPD
- □ Diabetes
- □ Dyslipidemia
- □ Heart Failure
- □ Hypertension
- □ Impaired Glucose Tolerance / Impaired Fasting Glucose
- □ Weight Management
- □ Other – describe below

□ Dietitian – please describe below

□ Pharmacist for □ Medication Review □ Narcotic Review

Please describe specific concerns:

PHYSICIAN INFORMATION

Lab Values: Current lab values will be accessed by the CPCN via *NetCare*. **With my signature I authorize implementation of the CPCN CDM Program Protocol *CDM Lab Schedule & Adverse Events* and I give permission for the PCN Risk Reduction Team to order lab values in my name using my lab ID number.**

Signature _____ Lab ID # _____
Results will be sent to your clinic as per usual procedure. It remains your responsibility to review these lab results and to provide necessary follow up action. The CPCN will be in communication with you regarding newly ordered lab results as they may affect the patient's program plan.

Revised Oct 2017