Calgary Foothills PCN Referral Form

The best way to view this form is by downloading it, and opening it in a PDF viewer.

Date: _____ **Referral/Consult** :

Destination fax:_____ **Referring physician's fax**:_____

Patient label	***Physician stamp***
Name: DOB: Gender: PHN: Address: Phone:	Name: Clinic: Clinic address: Clinic fax: Clinic phone: PRAC ID:

Reason for referral: ***What is the clinical question?***
Please include all additional information requested according to the Calgary Foothills PCN Quick Reference. If insufficient information is provided, your referral will be sent back.

Duration of symptoms/intensity:

Medication/Allergies:
Current:

Past:

Tele-Consults only: Physician's DIRECT phone _____

Preferred appointment time _____(time) _____(date) _____(month)

Actual appointment time* _____(time)_____ (date)_____ (month) ** filled out by specialist*

☐ Please check if a referral has already been sent.

Referring physician's signature: _____

This referral form is for Calgary Foothills PCN member physicians only.

Updated April 13 , 2017
www.cfpcn.ca

Agreement: WinRho

Patient label	*Physician stamp*
Name:	Name:
DOB:	Clinic:
Gender:	Clinic address:
PHN:	Clinic phone
Address:	Clinic fax :
Phone:	PRAC ID:

WinRho injection through the Access 365 Clinic

WinRho injection to be given on this date: _____
(date determined by referring physician)

☐ Patient has been advised of risks, benefits, and side effects of WinRho.

LMP: _____

EDD: _____

ABO/Rh: (Attach most recent copy)

Printed Name: _____

Physician Signature: _____

Date: _____

Fax this form to: 403-210-1382

Forms available at www.cfpcn.ca
Updated December 18, 2014

Referral and Patient Prescription: Tobacco Cessation

Patient label	*Physician stamp*
Name:	Name:
DOB:	Clinic:
Gender:	Clinic address:
PHN:	Clinic phone #
Address:	Clinic fax:
Phone:	PRAC ID:

Check off one of the following

- ◯ My patient is interested in attending the CFPCN group tobacco cessation program now.
- ◯ My patient is not yet ready to stop smoking. Please re-contact in three months.

Verify that you are the attending physician

- ◯ I hereby acknowledge that I am the attending physician of this patient.

<u>Please check off</u> each medication prescription that may be filled by your patient

Nicotine Replacement Therapy	Prescription Medications
◯ Nicotine Replacement Therapy as directed (refill x 18 months)	◯ Bupropion SR (Zyban) 150mg OD x 3 days; then 150mg BID x 12 weeks; 1 refill
	◯ Varenicline (Champix) Starter pack x 2 weeks. Then refill either: 1 mg BID x 12 weeks with 1 refill **OR** 0.5mg BID 12 weeks with 1 refill if higher dose not tolerated

NOTE: THIS IS A LEGAL PRESCRIPTION.

Follow up is to be with the prescribing physician. CFPCN Tobacco Cessation group facilitators will review medication mechanism of action, side effects and contraindications. Upon request of the patient, this prescription will faxed to their pharmacy by the CFPCN pharmacist facilitator. A fax will be sent to your office advising that this prescription faxed to the patient's pharmacy within two business days.

Printed Physician Name: _____

Physician Signature: _____

Date: _____

Fax completed form to 403-284-9518. We will contact your patient to book.

Updated November 7, 2014

This referral and prescription is valid for one year from the date indicated