**HEALTH PROFESSIONAL REFERRAL FORM**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** \_\_\_\_\_dd \_\_\_\_\_\_\_mmm \_\_\_\_\_\_\_\_\_\_ yyyy

**AHC: \_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Referral Type**  ***(check all that apply)*** | **Reason** | **Recommendations** | **Routine**  **4-6 weeks** | **URGENT**  **Within 1 week** |
| **Emergency department for urgent care** |  |  |  |  |
| **Care worker** |  |  |  |  |
| **Community aboriginal diabetes worker** |  |  |  |  |
| **Diabetes educator** |  |  |  |  |
| **Dietician** |  |  |  |  |
| **Massage Therapist** |  |  |  |  |
| **Occupational Therapist** |  |  |  |  |
| **Orthotist** |  |  |  |  |
| **Pedorthist/Podiatrist** |  |  |  |  |
| **Pharmacist** |  |  |  |  |
| * **Physician:**   **Endocrinologist**  **Neurologist**  **Dermatologist**  **Primary care physician**  **Vascular Surgeon**  **Orthopedic Surgeon** |  |  |  |  |
| **Physiotherapist** |  |  |  |  |
| **Social Worker** |  |  |  |  |
| **Traditional Healer** |  |  |  |  |
| **Other:** |  |  |  |  |