

Allied Health Referral Request

AB Fax #'s
 Airdrie/Calgary: 403-250-3055
 Edmonton/Lloydminster: 780-498-2729
 Red Deer: 403-346-0427

Please complete the screening tools below. If your patient screens positive and a referral to Careica is recommended, please fax this form to us and we will coordinate with the patient's family physician for signature authorization.

ALLIED HEALTH INFORMATION

Company/Clinic Name _____

Date ____ DD ____ MM ____ YY

Referrer Name _____

Phone _____

Allied Health Professional Pharmacist RN RD Other: _____

PATIENT INFORMATION

Patient Name _____
(First & Last)

Email _____

Street Address _____

Date of Birth ____ DD ____ MM ____ YY Sex M F Identifies as:

City/Town _____

Family Physician _____

Postal Code _____

Clinic Name _____

Phone _____

Clinic Phone _____

SLEEP

Stop Bang Screening Tool¹ Y N

- Do you snore loudly? Louder than talking, or to be heard through closed doors?
- Do you often feel tired, fatigued, or sleepy during the daytime?
- Has anyone observed you stop breathing during your sleep?
- Do you have, or are you being treated for high blood pressure?
- BMI greater than 35?
- Age over 50 years old?
- Neck circumference: > 43 cm (> 17 in)?
- Are you male?

Stop Bang Score (# of Yes answers) _____²

Referral to Careica: Level III Sleep Study

¹ Chung F et al J Clin. Sleep Med. Sept 2014. <http://www.stopbang.ca/osa/screening.php>
² A Level III Sleep Study is recommended for patients who score 3 or greater.

PULMONARY FUNCTION (Calgary/Airdrie only)

Canadian Lung Health Test³ Y N

- Do you cough regularly?
- Do you cough up phlegm regularly?
- Do even simple chores make you short of breath?
- Do you wheeze when you exert yourself, or at night?
- Do you get frequent colds that persist longer than those of other people you know?

If you answered YES to one or more of the questions, you may be at risk for COPD.

Referral to Careica: Spirometry Testing

³ Canadian Thoracic Society's COPD Clinical Assembly & Canadian Lung Association. Canadian Lung Health Test. May 2015. <https://www.lung.ca/lung-health/lung-disease/copd/symptoms>

I hereby confirm that all of the above information is correct and complete, and authorize Careica Health to follow-up with me and to release any part or all of this information to my physician(s) as it pertains to the Referral to Careica indicated through the screening tools used on this form. Careica Health agrees to keep your information confidential.

Patient Signature: _____

Date: ____ DD ____ MM ____ YY

