Vancouver CoastalHealth
Promoting wellness. Ensuring care.

North Shore Chronic Disease Services Referral (v.2017)

West Vancouver Community Centre, Room 241, 2121 Marine Drive, West Vancouver V7V 4Y2

(Sept 2016) NEW FAX: 604-297-9681

This form is regularly updated. Access latest version at:
http://vch.eduhealth.ca/PDFs/EF/EF.850.N67.pdf

Referrer Stamp: (name, phone, fax)

MSP Billing #:

Patient Profile

Surname	Given Name	
PHN	DOB (d/m/y)	M/F
Address/PC		
Primary Phone #	Email	

Reason for Referral:

Please note any precautions or safety measures that should be considered in meeting this patient.

MEDICAL HISTORY:

Medications:

Suitable for Group? ❑ Yes ❑ No
Barriers to Communicate (if any):
Interpreter required: ❑ Yes ❑ No
Language: _____

Prediabetes & Diabetes

☐ PREDIABETES AND DIABETES EDUCATION PROGRAMS
Please circle: Prediabetes Type 1 Type 2
Date of Diagnosis: _____

☐ GESTATIONAL DIABETES
Due Date: _____
OGTT Results: _____

☐ DIABETES FOOT CARE PROGAM **(no open wounds)**

Child/Youth/Young Adult Clinics

Please circle: Insulin Resistance Type 1 Type 2
Date of Diagnosis: _____

REQUIRED FOR ALL DIABETES REFERRALTRIAGE:
FBS and/or A1c; Lipid Panel; ACR (*If available*: GTT)

INSULIN STARTS-Require orders for insulin type and dose:
Insulin _____ Dose: _____

Respiratory

☐ ASTHMA EDUCATION PROGRAM
☐ COPD EDUCATION PROGRAM
☐ RESPIRATORY REHABILITATION - BREATH PROGRAM

REQUIRED:
Medical Hx (within 1 yr), Pulmonary Function (within 3 yrs), ECG (within 6 mos), and Chest X-ray (within 1 year)

Healthy Eating & Active Living

☐ OUTPATIENT NUTRITIONAL COUNSELLING PROGRAM
[nutrition support for (pre)diabetes, please refer to section above]

Mental Health

☐ BOUNCE BACK PROGRAM (Should **NOT** be at risk to harm self/others **OR** significantly misusing substances **OR** dx with personality disorder **OR** manic episodes in past 6 months)
☐ EVERY DAY COUNTS PSYCHOSOCIAL PROGRAM
☐ (ON HOLD/NOT ACCEPTING NEW REFERRALS) CDM COUNSELLING PROGRAM (also known as the IPCC Counselling Program)

Other Chronic Conditions

☐ CARDIAC REHAB AND CARDIOMETABOLIC PROGRAM
☐ OASIS – Osteoarthritis Service Integration System

REQUIRED:
Recent and relevant laboratory results
Affected Joints _____
X-ray (within last year)

Chronic Disease Management, Care Coordination for Patients with Complex Health Needs

☐ CHRONIC DISEASE NURSE COORDINATOR PROGRAM

REQUIRED:
Medical Hx, Medications, Lab results, Diagnostic reports, Other tests

Please Attach Additional Info with Referral. *See Reverse Side for Program Descriptions.*

North Shore Chronic Disease Services Program Descriptions FAX: 604-297-9681

Prediabetes & Diabetes Programs

PREDIABETES AND DIABETES EDUCATION PROGRAMS (t. 604-984-5752 ext 2) – Series of education classes and/or individual appointments in self-management. Team may include a RN, RD and Exercise Specialist.
GESTATIONAL DIABETES PROGRAM (t. 604-984-5752 ext 2) – For pregnant women who have type 1, type 2 or gestational diabetes; includes group education and individual appointments with RN and RD. May meet with an Endocrinologist if required.
DIABETES FOOT CARE PROGRAM (t. 604-984-5752 ext 2) – Assessment and education for foot care with a special focus on prevention of foot ulcers and lower extremity amputations. It may include RN and OT. **NO OPEN WOUNDS**. **Service fees apply.**
CHILD/YOUTH/YOUNG ADULT CLINICS: Multi-disciplinary team may include a Pediatric Endocrinologist, Nurse, Dietitian, and Child & Youth Mental Health Clinician.

Respiratory

RESPIRATORY DISEASE EDUCATION PROGRAM (t. 604-988-3131, local 4954) – For clients with **Asthma** or **COPD**. Program teaches the basics of asthma or COPD and provides self-management strategies. Can provide smoking cessation counselling to prevent disease from developing or worsening, as required. Also provides instruction on how to recognize and manage an asthma or COPD flare up with an individually tailored action plan. One on one session with follow up by phone.

RESPIRATORY REHABILITATION-BREATH PROGRAM (t. 604-988-3131, local 4940) - The **Breath Respiratory Rehabilitation program** is a 5-week program of exercise, education and social support for COPD clients and their families. The team includes a Respirologist, OT, PT and RN.

Healthy Eating & Active Living

NUTRITIONAL COUNSELLING PROGRAM (t. 604-984-5752 ext 2) – Offers group education or individual appointments by an RD for patients of all ages and types of diets [except (pre)diabetes – please direct referral to (Pre)Diabetes program]. RD will triage into appropriate program. **A fee applies only to the *BodySense Program*.**

Mental Health

BOUNCE BACK PROGRAM (t. 604-929-2199) – Offers brief, structured coaching over the phone by a community coach on self-management of mood and worry for patients living with a chronic disease or chronic pain.

EVERY DAY COUNTS PSYCHOSOCIAL PROGRAM (t: 604-363-0961) – Offers confidential individual and group counselling and music therapy, as well as advocacy, resources, wellness and self-management skills to individuals living with a life limiting physical illness and their family. Referral to EDC ensures follow through from diagnosis to family bereavement support.

(ON HOLD) CDM (IPCC) COUNSELLING PROGRAM (t. 604-987-6959, ext. 228) – Not accepting referrals at this time.

Other Chronic Conditions

CARDIAC REHAB AND CARDIOMETABOLIC PROGRAM (t. 604-904-0810) – Offers individual counseling to establish an exercise program, diet and lifestyle modifications for patients with cardiac risk factors or those who have an established cardiac condition. The team includes a clinical educator, exercise specialist, and program specialist physicians. Service fees apply.

OASIS – Osteoarthritis Service Integration System (t. 604-904-6177) – Offers assessment, education and referral to support services for the self-management of osteoarthritis at any stage of the disease. The team includes PT, OT and RN.

Chronic Disease Management, Care Coordination for Patients with Complex Health Needs

CHRONIC DISEASE NURSE COORDINATOR PROGRAM (t. 604-904-6200 ext 4115) – Offers guideline-based chronic disease management for patients with two or more chronic conditions. A Chronic Disease Nurse will work closely with clients, their family, and physician to support and manage their chronic diseases. **Referral must come from a physician.**

****Patients who require tobacco cessation support can be directed to call 811****