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403-943-2584

Triage Category	Including, but not limited to:	Process	Approximate time to be seen
<b>Routine</b>  <b>For all services</b>	Referral can be initiated by: <ul style="list-style-type: none"> <li>• physicians</li> <li>• health-care providers</li> <li>• patients</li> <li>• caregivers</li> </ul> All referrals are considered routine	<ul style="list-style-type: none"> <li>• Call <b>403-943-2584</b> (403-9-HEALTH) OR</li> <li>• Fax referral to: <b>403-955-6868</b></li> </ul> If faxing the referral, provide pertinent information as outlined in the Central Access and Triage Guide referral form	Patient is contacted within 48 hours of receipt of referral

**Criteria for all Living Well services**

- At least one chronic condition
- Must be able to participate in group setting, except for the one-on-one dietitian counselling
- Must be cognitively capable of participating in assessment and treatment (for exercise program)

Locations - Multiple sites within Calgary and rural areas

Languages - Some classes are offered in Chinese, Punjabi, Tagalog and Spanish

**Services Provided****Explanation****Supervised Exercise Program**

\$80.00 for 8 weeks

Subsidies available to those who qualify.

Classes are led by health-care professionals and fitness leaders

Easy Going - For individuals who can weight bear and ambulate independently with or without a walking aid. If clients are ambulatory but require assistance with transfers they will be assessed for appropriateness and will require a support person to attend with them. Focus is primarily on improving mobility and balance.

Get Going - For individuals with some limitations to exercise who require a moderate level of monitoring. Focus is primarily on aerobic endurance, muscular strength/endurance, flexibility and balance.

Keep Going - For individuals with some limitations to exercise that require minimal supervision. Focus is primarily on improving aerobic endurance, muscular strength/endurance, flexibility and balance.

**Disease-Specific and General Education classes**

Free

Classes are offered in a variety of formats for varying lengths of time depending on the topic.

Classes are interactive and led by a variety of health-care professionals

Topics available:

- Arthritis
- Blood Pressure
- Celiac Disease
- Cholesterol
- Chronic Pain
- Diabetes
- Exercise
- Falls Prevention
- Food and Mood
- Hoping and Coping
- Kidney Health
- Lung Disease
- Nutrition
- Osteoporosis
- Parkinson's Disease
- Pre-diabetes
- Sleep Hygiene and information
- Smoking Cessation
- Stress Management
- Stroke

## Living Well with a Chronic Condition Program (cont)

### Self Management – Better Choices, Better Health™

Free  
2.5 h/wk for 6 weeks

Classes are led by trained leaders  
who also have chronic conditions

Participants learn and practice the skills they need to take control and live successfully with their chronic conditions.

Topics:

- Goal setting and problem solving
- Coping with pain and fatigue
- Managing difficult emotions such as frustration and fear
- Relaxation techniques
- Self talk
- Communication and creating positive relationships with the health care team

### Dietitian Counselling

Free

Nutrition counselling available for all listed conditions:

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>• Celiac Disease</li> <li>• Colitis</li> <li>• Constipation</li> <li>• Crohn's Disease</li> <li>• Diabetes</li> <li>• Diarrhea</li> <li>• Diverticular Disease</li> <li>• Fatty Liver</li> <li>• Dyslipidemia</li> <li>• Food Allergy/Intolerance</li> <li>• Gastroesophageal Reflux Disease</li> <li>• Gout</li> <li>• Hepatitis</li> <li>• Hypertension</li> </ul> | <ul style="list-style-type: none"> <li>• Hypoglycemia</li> <li>• Irritable Bowel Syndrome</li> <li>• Kidney Health</li> <li>• Kidney Stones</li> <li>• Liver Cirrhosis</li> <li>• Malnutrition</li> <li>• Pancreatitis</li> <li>• Pre-diabetes</li> <li>• Prenatal Concerns</li> <li>• Renal (GFR &gt;30)</li> <li>• Short Bowel</li> <li>• Sleep Apnea</li> <li>• Unexplained weight loss</li> <li>• Other</li> </ul> |
|---|--|

### Social Worker

Social worker counselling is available for those already in a Living Well program or for those patients who have been managed by an AHS-CDM nurses.

## Mental Health

403-943-1500

Triage Category	Including, but not limited to:	Process	Approximate time to be seen
<b>Emergent</b>	Clinical situation where there is an imminent risk of harm or death to self or others i.e. serious suicidal states, violent states or states of seriously impaired judgment, delirium, dementia, acute psychosis, severe dissociative state. Querying admission to hospital.	<ul style="list-style-type: none"> <li>Connect patient with crisis resources i.e. Emergency department, MRT (contact MRT through distress centre).</li> </ul>	N/A - Direct to emergency services.
<b>Urgent</b>	Acute but not necessarily severe disorders or issues that necessitate the need for urgent attention to prevent further decompensation i.e. displaying some signs of psychosis, suicidal ideation without intent, postpartum depression.	<ul style="list-style-type: none"> <li>Fax referral to Access Mental Health: <b>403-943-9044</b></li> <li>or</li> <li>Call Access Mental Health: <b>403-943-1500</b> 8 am - 5 pm Monday - Friday</li> </ul>	Prioritized and processed by Access Mental Health within 1-2 business days and directed to appropriate resource. Appointments to be booked by receiving program.
<b>Semi Urgent/ Routine</b>	Requesting psychiatric consult for mild to moderate mood disorder, anxiety disorder, or medication consultation. Patient requires counselling for ongoing life stressors and is not in an acute state.	<ul style="list-style-type: none"> <li>Fax referral to Access Mental Health: <b>403-943-9044</b></li> </ul>	Average 10 business days for referral to be processed by Access Mental Health and directed to appropriate resource. Appointments to be booked by receiving program.
<b>Specific co-morbidity information to identify if relevant:</b> <ul style="list-style-type: none"> <li>Current GAF/GAS</li> <li>Suicidal/self injury risk assessment</li> <li>Illicit substance use or abuse</li> <li>Is the client involved with the legal system? Pending charges? On probation?</li> <li>Is the client their own legal guardian? If not who is?</li> <li>If child, is child welfare involved?</li> </ul>		<b>Specific symptom information to identify if relevant:</b> <ul style="list-style-type: none"> <li>Provide all considered relevant by the referring source.</li> </ul>	
<b>Specific tests/investigations required to enable triage:</b> <ul style="list-style-type: none"> <li>Attach any psychiatric consultations, reports or hospital admission records within past year.</li> </ul>			

## Nephrology

403-955-6389

Triage Category	Including, but not limited to:	Process	Approximate time to be seen
<b>Emergent</b>	<ul style="list-style-type: none"> <li>Life-threatening uremic symptoms</li> <li>Serum creatinine <math>\geq 500</math> <math>\mu\text{mol/L}</math></li> <li>Marked hyperkalemia <math>&gt; 6.5</math> <math>\text{mmol/L}</math></li> <li>Pulmonary edema and renal failure</li> <li>Pericarditis and renal failure</li> </ul>	<ul style="list-style-type: none"> <li>Page nephrologist on call: <b>403-944-1110</b></li> </ul>	Same day (emergency)
<b>Urgent</b>	<ul style="list-style-type: none"> <li>Rapid decline in renal function /GFR over days to weeks</li> <li>GFR declining over weeks to months PLUS hematuria and/or proteinuria</li> <li>GFR <math>&lt; 15</math> <math>\text{mL/min}</math></li> <li>Acute Nephrotic syndrome (<math>\geq 3</math> <math>\text{g/d}</math> proteinuria, or PCR <math>\geq 0.35</math> <math>\text{g/mmol}</math>, or ACR <math>\geq 350</math> <math>\text{mg/mmol}</math>)</li> <li>Suspected vasculitis / autoimmune disease in the setting of hematuria and/or proteinuria</li> </ul>	<ul style="list-style-type: none"> <li>Fax referral to Nephrology Central Access &amp; Triage: <b>403-955-6776</b></li> </ul>	2-3 weeks
<b>Semi Urgent</b>	<ul style="list-style-type: none"> <li>Chronic kidney disease at high risk of progression (<math>\geq 3</math> <math>\text{g/day}</math> proteinuria, or PCR <math>\geq 0.35</math> <math>\text{g/mmol}</math>, or ACR <math>\geq 350</math> <math>\text{mg/mmol}</math>)</li> <li>GFR 15-30 <math>\text{mL/min}</math></li> </ul>	<ul style="list-style-type: none"> <li>Fax referral to Nephrology Central Access &amp; Triage: <b>403-955-6776</b></li> </ul>	4-6 weeks
<b>Routine &lt; 3 months</b>	<ul style="list-style-type: none"> <li>Chronic kidney disease at moderate risk of progression (1-3 <math>\text{g/d}</math> proteinuria, or PCR 0.12-0.35 <math>\text{g/mmol}</math>, or ACR 120-350 <math>\text{mg/mmol}</math>)</li> <li>Chronic kidney disease worsening over months (GFR <math>\geq 30</math> <math>\text{mL/min}</math>)</li> <li>Patients with diabetes AND GFR <math>&gt; 30</math> <math>\text{mL/min}</math> AND significant proteinuria (<math>&gt; 1</math> <math>\text{g/day}</math>, or PCR <math>\geq 0.12</math> <math>\text{g/mmol}</math>, or ACR <math>\geq 120</math> <math>\text{mg/mmol}</math>)</li> <li>GFR <math>&gt; 60</math> <math>\text{mL/min}</math> AND proteinuria (1-3 <math>\text{g/day}</math>, or PCR 0.12–0.35 <math>\text{g/mmol}</math>, or ACR 120-350 <math>\text{mg/mmol}</math>)</li> </ul>	<ul style="list-style-type: none"> <li>Fax referral to Nephrology Central Access &amp; Triage: <b>403-955-6776</b></li> </ul>	< 3 months
<b>Elective &lt; 6 months</b>	<ul style="list-style-type: none"> <li>Stable chronic kidney disease without risk factors for progression (i.e. proteinuria <math>&lt; 1</math> <math>\text{g/day}</math>, or PCR <math>&lt; 0.12</math> <math>\text{g/mmol}</math>, or ACR <math>&lt; 120</math> <math>\text{mg/mmol}</math>)</li> <li>Chronic kidney disease with slow deterioration over years</li> <li>Diabetes with normal kidney function and microalbuminuria</li> <li>Nephrolithiasis prophylaxis*</li> <li>Electrolyte disorders</li> <li>Metabolic acidosis</li> </ul>	<ul style="list-style-type: none"> <li>Fax referral to Nephrology Central Access &amp; Triage: <b>403-955-6776</b></li> </ul>	< 6 months

## Nephrology (cont)

403-955-6389

### Specific co-morbidity information to identify if relevant:

- Type 1 or Type 2 Diabetes
- Hypertension: controlled or uncontrolled
- Coronary artery disease
- Congestive heart failure
- Cerebrovascular disease
- Cancer (non-skin)
- Peripheral vascular disease
- Autoimmune disease (describe)

### Specific symptom information to identify if relevant:

- Elevated serum creatinine (decreased GFR)
- Proteinuria
- Hematuria
- Urolithiasis

### Specific tests/investigations required to enable triage:

#### Mandatory:

- Recent eGFR i.e. Serum Creatinine (including multiple measurements over previous years)
- Recent Routine urinalysis

### Other tests that may assist triaging

- Electrolytes
- Ca ++
- Phosphate
- CBC
- Random glucose
- HbA1C (if patient has diabetes)
- Fasting lipid profile (within the last year)
- Renal ultrasound (only if done)

### Note:

**Referrals for acute nephrolithiasis and renal masses suspicious for malignancy should be referred to Urology.**

## Respiratory Medicine

403-943-4718

Triage Category	Including, but not limited to:	Process	Approximate time to be seen
<b>Urgent</b>	<ul style="list-style-type: none"> <li>• Suspicious for lung cancer</li> <li>• Recurrent ER visits for respiratory symptoms</li> <li>• Hemoptysis</li> </ul>	<ul style="list-style-type: none"> <li>• Fax referral to Respiratory Medicine Central Access &amp; Triage: <b>403-944-1250</b></li> </ul>	Within 1-2 weeks
<b>Semi Urgent</b>	<ul style="list-style-type: none"> <li>• Asthma /COPD</li> <li>• Interstitial lung disease, not yet diagnosed</li> <li>• Pulmonary hypertension</li> <li>• Progressive neuromuscular disease</li> </ul>	<ul style="list-style-type: none"> <li>• Fax referral to Respiratory Medicine Central Access &amp; Triage: <b>403-944-1250</b></li> </ul>	Within 6-8 weeks
<b>Routine</b>	<ul style="list-style-type: none"> <li>• Cough</li> <li>• Pulmonary rehabilitation</li> </ul>	<ul style="list-style-type: none"> <li>• Fax referral to Respiratory Medicine Central Access &amp; Triage: <b>403-944-1250</b></li> </ul>	Within 10-12 weeks
<b>Specific co-morbidity information to identify if relevant:</b> <ul style="list-style-type: none"> <li>• Provide all considered relevant by the referring source</li> </ul>		<b>Specific symptom information to identify if relevant:</b> <ul style="list-style-type: none"> <li>• Provide all considered relevant by the referring source.</li> </ul>	
<b>Specific tests/investigations to provide if available:</b> <ul style="list-style-type: none"> <li>• Spirometry /pulmonary function testing reports</li> <li>• Chest imaging reports</li> <li>• Echocardiograms and other cardiac testing</li> </ul>			

## Rheumatology

403-944-4426

Triage Category	Including, but not limited to:	Process	Approximate time to be seen
<b>Urgent</b>	<ul style="list-style-type: none"> <li>• Suspected septic arthritis</li> <li>• Aggressive connective tissue disease or systemic vasculitis</li> <li>• Temporal Arteritis</li> </ul>	<ul style="list-style-type: none"> <li>• Page rheumatologist on call: <b>403-944-1110</b></li> <li>• Fax referral to: <b>403-944-4430</b></li> </ul>	Within 24 hours
<b>Semi Urgent</b>	<ul style="list-style-type: none"> <li>• Early Inflammatory Arthritis</li> <li>• Acute monoarthritis (non-septic)</li> <li>• Polyarthritis with functional impairment</li> <li>• Connective tissue disease which is active, but not life threatening</li> <li>• Polymyalgia Rheumatica</li> </ul>	<ul style="list-style-type: none"> <li>• Fax referral to: <b>403-944-4430</b></li> <li>• If concerned re: patient, or patient's condition changes from initial referral, phone <b>403-944-4426</b> to discuss.</li> </ul>	1-8 weeks
<b>Moderate</b>	<ul style="list-style-type: none"> <li>• Joint Effusions</li> <li>• Gout</li> </ul>	<ul style="list-style-type: none"> <li>• Fax referral to: <b>403-944-4430</b></li> </ul>	2-4 months
<b>Routine</b>	<ul style="list-style-type: none"> <li>• Painful degenerative arthritis</li> </ul>	<ul style="list-style-type: none"> <li>• Fax referral to: <b>403-944-4430</b></li> </ul>	8 months or longer
<b>Specific co-morbidity information required:</b>		<b>Specific symptom information required:</b>	
<ul style="list-style-type: none"> <li>• Provide all considered relevant by the referring source.</li> </ul>		<ul style="list-style-type: none"> <li>• Provide all MSK and autoimmune related symptoms.</li> </ul>	

**Specific tests/investigations required to enable triage:**

- CBC
- ESR
- CRP
- Rheumatoid Factor
- Urea
- Electrolytes
- Creatinine
- Uric acid
- Urinalysis
- Liver functions
- ENA profile to Dr. Fritzler's lab ordered through CLS (if concerned re: systemic rheumatic disease)
- Anti CCP – if concerned re Inflammatory Arthritis
- X-rays of symptomatic joints if applicable and if available
- Anti CCP – if concerned re: inflammatory arthritis or rheumatoid arthritis

## Senior's Health &amp; Geriatric Medicine

403-955-1525

Triage Category	Including, but not limited to:	Process	Approximate time to be
<b>Emergent</b>	<ul style="list-style-type: none"> <li>Acute confusion (delirium)</li> <li>Disruptive behaviour in the setting of a dementia</li> <li>New onset immobility</li> </ul>	<ul style="list-style-type: none"> <li>Go to Emergency</li> </ul>	Same day (emergency)
<b>Urgent</b>	<ul style="list-style-type: none"> <li>Recent or sub-acute decline in function</li> <li>Failure to cope at home (especially if safety concerns/caregiver burn-out)</li> <li>Multiple falls in a short period of time</li> <li>Rapid decline in cognition</li> </ul>	<ul style="list-style-type: none"> <li>Fax referral to Senior's Health One-Line Referral: <b>403-955-1514</b></li> <li>Referral may be forwarded to a more appropriate Alberta Health Services - Calgary Zone service</li> </ul>	1-2 weeks
<b>Routine</b>	<ul style="list-style-type: none"> <li>Comprehensive geriatric assessment/ Advice on management of medically complex or frail clients</li> <li>Falls</li> <li>Cognitive concerns including access to Neuropsychological testing</li> <li>Functional decline</li> <li>Review of medication</li> <li>Second opinion/advice on management of a dementia</li> </ul>	<ul style="list-style-type: none"> <li>Fax referral to Senior's Health One-Line Referral: <b>403-955-1514</b></li> </ul>	2-4 months
<b>Not Accepted</b>	<ul style="list-style-type: none"> <li>Referrals for adults &lt;65 yrs.</li> <li>Referrals for capacity assessment or driving assessment</li> <li>Referrals for medical-legal assessments</li> <li>Referrals for third party assessments ( Immigration assessments, WCB assessments, fitness to work, placement issues, co-signatures for PD &amp; EPOA)</li> <li>Referrals for primary mental health issues should be directed to Community Geriatric Mental Health Services (CGMHS).</li> <li>Referrals for moderate and severe BPSD (Behavioral &amp; Psychological Symptoms of Dementia) should be directed to CGMHS.</li> </ul>	<p>For cognitive assessment of clients &lt; 65, fax referral to:</p> <p>Neurosciences Cognitive Assessment Clinic <b>403-944-8228</b></p> <p>CGMHS Phone: <b>403-955-6155</b> Fax: <b>403-955-6169</b></p>	

Seniors Health Clinics/ services/ programs provide multidisciplinary, consultative advice on the diagnosis and management of adults age 65 or older with issues relating to medical complexity, frailty and chronic disease, functional decline, cognitive impairment, dementia or falls. Referrals will be accepted from family physicians/ specialists. Referrals from Home Care are accepted provided that the family physician is aware and agrees with sending the referral.

**Required information :**

Goals or clear reason for referral  
 Consults from other specialists ( last 2 -3 years)  
 Results of cognitive testing (last 2-3 yrs.)  
 Current medication list

**Specific Tests:**

Recent blood work  
 Diagnostic imaging

## Senior's Health & Geriatric Medicine (cont)

403-955-1525

Please specify if appropriate which subspecialty clinic within Seniors Health you consider your patient will likely need to be seen by:

### Seniors Health Clinics (RGH and Bridgeland)

#### Calgary Fall Prevention Clinic

An in-home assessment is completed by a healthcare professional trained in falls prevention. Fall risks are identified and specific recommendations are provided to the client and family physician. Patients must have fallen within the last 12 months and cognitively be able to benefit from the assessment (mini-mental status exam of 20/30 or greater).

#### Carewest Day Hospital (North & South)

A time-limited ambulatory treatment and rehabilitation program for frail seniors who are living at home with medical and functional concerns, at risk for hospitalization or care centre admission. The focus is to promote their well-being, functional abilities, and quality of life, through comprehensive assessment and treatment by an interdisciplinary team with expertise and experience in the care of frail elderly.

##### Activities/Services include:

- Collaborative assessment completed by team (social worker, physical therapist, occupational therapist, recreation therapist, physician, and nurse; further assessment, treatment, and /or consultation available from a speech language therapist, psychologist, geriatrician, geriatric psychiatrist, and pharmacist).
- Client centred, functional goals and treatment plan developed in collaboration with client, and family and/or other care providers.
- Integrated therapy and treatment, including both individual and group activities.
- Links to appropriate community programs and services
- Discharge plan communicated to family physician, referral source, and home care (if involved).
- Clients normally attend five hours twice per week for three to four months

#### Carewest Dealing with Dementia

A time-limited ambulatory service for seniors with specific needs related to dementia, along with their caregivers. The intent is to increase caregivers' knowledge, skill and coping to enable them to better provide support and care for their family member and to maintain their own well-being.

##### Activities/Services include:

- Assessment, diagnosis and treatment by interdisciplinary team including geriatric psychiatrist.
- Interactive education sessions for primary caregivers
- Participation by the client and caregiver in group activities; modeling and coaching by the team.
- Supportive counselling; and linking with community services.
- Anticipated progress and needs of both client and family addressed.
- Clients and their caregivers normally attend four to five hours once per week for thirteen weeks

## Sleep Centre

403-944-2404

Triage Category	Including, but not limited to:	Process	Approximate time to be seen
<b>Urgent</b>	<ul style="list-style-type: none"> <li>• Severe daytime somnolence</li> <li>• Respiratory failure</li> <li>• Pulmonary HTN, cardiomyopathy, uncontrolled HTN</li> </ul>	Fax referral to: <b>403-270-2718</b>	Within 1-2 months
<b>Semi Urgent</b>	<ul style="list-style-type: none"> <li>• Moderately severe daytime somnolence</li> </ul>	Fax referral to: <b>403-270-2718</b>	Within 2-4 months
<b>Routine</b>	<ul style="list-style-type: none"> <li>• Normal daytime somnolence</li> </ul>	Fax referral to: <b>403-270-2718</b>	Approximately 12-18 months
<p><b>Specific co-morbidity information required:</b></p> <ul style="list-style-type: none"> <li>• Congestive Heart Failure *</li> <li>• Ischemic Heart Disease *</li> <li>• Cardiac Arrhythmias *</li> <li>• Respiratory Failure (PO<sub>2</sub> &lt; 50, PCO<sub>2</sub> &gt; 50) *</li> <li>• Stroke (specify year/s)</li> <li>• Other Respiratory Disease</li> <li>• Neuromuscular Disease</li> <li>• Other Neurologic Disease</li> </ul> <p>* Please see Subspecialty section below for required documents.</p>		<p><b>Specific symptom information required:</b></p> <ul style="list-style-type: none"> <li>• Please indicate nature of Severe Daytime Somnolence, including but not limited to:               <ul style="list-style-type: none"> <li>o Patient falls asleep and is at risk at work (please specify profession)</li> <li>o Patient falls asleep while driving (please specify how often, and whether any accidents have occurred)</li> <li>o Patient is a professional driver</li> </ul> </li> <li>• Please indicate if your patient is going for major surgery within the next 6 months and the reason.</li> </ul>	
<p><b>Specific tests/investigations required:</b></p> <ul style="list-style-type: none"> <li>• Congestive Heart Failure, Ischemic Heart Disease and Cardiac Arrhythmias:               <ul style="list-style-type: none"> <li>o Reports of recent investigations (Echo, MUGA,Angio, PFT's if available)</li> </ul> </li> </ul> <p><b>Respiratory Failure:</b></p> <ul style="list-style-type: none"> <li>• Reports of recent investigations (PFT's,ABG's, Echo if available)</li> <li>• Current treatment (oxygen, CPAP, BiPAP)</li> </ul>			

## Southern Alberta HIV Clinic (SAC)

403-955-6399

Triage Category	Examples	Process	Time to be seen
<b>Routine</b>	<ul style="list-style-type: none"> <li>All referrals to the Southern Alberta HIV Clinic (SAC) are considered routine and treated equally.</li> <li>All patients must have a positive HIV result, as SAC does <b>not</b> perform HIV screening tests.</li> </ul>	Fax referral form to SAC at <b>403-955-6355</b> , or call the clinic at <b>403-955-6399</b>	Within 1-2 weeks
<b>Specific co-morbidity information to identify if relevant:</b> <ul style="list-style-type: none"> <li>Provide all considered relevant by the referring source</li> <li>Active infections (e.g., active TB)</li> </ul>			
<b>Specific symptom information to identify if relevant:</b> <ul style="list-style-type: none"> <li>Provide all considered relevant by the referring source</li> </ul>			
<b>Specific tests/investigations to provide if available:</b> <ul style="list-style-type: none"> <li>Positive HIV result</li> <li>Recent hospital admission records (within past year), including location and approximate dates</li> </ul>			
<b>Additional subspecialty requirements to provide if available:</b> <ul style="list-style-type: none"> <li>Language needs</li> <li>Barriers to care (e.g., transportation issues)</li> </ul>			

## Vascular Risk Reduction Program

403-955-8032

Triage Category	Criteria	Process	Time to be seen
<b>Urgent</b>	Known atherosclerotic disease: MI/CABG or CVA/TIA within the past 3 months and/or Hgb A1c > 9.0	Fax referral to 403-955-8634	4 – 6 weeks
<b>Semi Urgent</b>	Known atherosclerotic disease: event greater than 3 months, or PAD or carotid disease.	Fax referral to 403-955-8634	8 – 10 weeks

### Specific tests/investigations required to enable triage:

History and Physical – most recent  
 Current Medications with dosage  
 Discharge summary (inpatients)  
 Hgb A1C for those with diabetes  
 Fasting glucose  
 Lipid Profile  
 Electrolytes  
 Creatinine  
 TSH  
 ALT and CK

### Specific comorbidity information to identify if relevant:

- Diabetes
- Thyroid Disease
- CAD
- PAD
- CVA/TIA
- Renal Disease
- Smoker

### Note:

The following conditions are not monitored or managed in this program:

- CHF
- Pulmonary HTN
- If a patient is on coumadin - INR's are not monitored in this program..



## Palliative/End of Life Care

403-944-2304

Service	Description	Patient Category	Process
<b>Acute Care</b>	<p>The Palliative Care consult teams provide support to patients, families, home care clinicians and family practitioners with concerns regarding the management of adult patients with complex palliative symptoms and/or issues related to his/her life-limiting disease, such as; palliative pain &amp; symptom management, psycho-social and spiritual concerns, education regarding disease progression and the end of life, prognosis and goals of care, accessing community resources, and transitioning to hospice. The team is comprised of palliative physicians, clinical nurse specialists and a clinical specialist in end-stage pulmonary disease.</p> <p>*Generally the patient's prognosis is anticipated to be within 1 year and the goal of care is comfort and symptom management.</p>	<b>Inpatient (Urban acute care site)</b>	<p>In Sunrise Clinical Manager, enter "Palliative Care Referral".</p> <p>For any questions related to Palliative Care or Palliative Care referrals phone:                      FMC: 403-944-2304                      PLC: 403-943-4950                      RGH: 403-943-8774</p>
		<b>Inpatient (Rural acute care site)</b>	Please see Rural Palliative Consult Team.
		<b>Outpatient</b>	Currently we do not provide outpatient services at acute care sites. Please refer to our Urban/Rural Teams.
<b>Intensive Palliative Care Unit (IPCU)</b>	<p>The Intensive Palliative Care Unit (IPCU) is a specialized unit for patients and their families who are experiencing severe and complex symptoms related to palliative care issues that cannot be managed in the community or on a general hospital unit. The IPCU at the Foothills Medical Centre in Calgary serves patients from all of Southern Alberta.</p> <p>A goal of the IPCU is to discharge patients to the most appropriate care setting when issues have been resolved.</p>		Referrals must be initiated by a physician on the Palliative Care Consult Team.
<b>Residential Hospice</b>	Residential hospices are available to palliative patients living in Calgary in their last days to weeks of life, whose care needs can no longer be met in their current care settings. Patients admitted to Hospice have a life-threatening illness where cure is no longer possible and whose goals of care are focused on quality of life and comfort care.		<p>Hospice referrals must be made by a Palliative Consultant or Palliative Home Care Coordinator and can be made by contacting Hospice Central Access.</p> <p>Hospice Central Access: 403-944-1614</p>

## Rural Palliative Consult Team

403-995-2714

Triage Category	Includes	Process	Approximate time to be seen
<b>Emergent</b>	<ul style="list-style-type: none"> <li>• Patient is actively dying requiring emergent pain/symptom management intervention</li> <li>• Family/Patient support</li> </ul>	<ul style="list-style-type: none"> <li>• Phone office then fax the completed referral form Phone: <b>403-995-2714</b> Fax: <b>403-995-2619</b></li> </ul>	Same day (if an in-person visit isn't possible then a phone consult will be provided)
<b>Urgent</b>	<ul style="list-style-type: none"> <li>• Death is imminent and there is a great need of pain/symptom management</li> <li>• Family/Patient support</li> </ul>	<ul style="list-style-type: none"> <li>• Phone office then fax the completed referral form Phone: <b>403-995-2714</b> Fax: <b>403-995-2619</b></li> </ul>	Within 24 hours (if an in-person visit isn't possible then a phone consult will be provided)
<b>Semi-Urgent</b>	<ul style="list-style-type: none"> <li>• Pain/symptom management</li> <li>• Family/Patient support</li> <li>• Cognitive/Functional deterioration</li> </ul>	<ul style="list-style-type: none"> <li>• Fax the completed referral form Fax: <b>403-995-2619</b></li> </ul>	Within 48 hours
<b>Routine</b>	<ul style="list-style-type: none"> <li>• Family/Patient support</li> <li>• End of Life Decision Making</li> </ul>	<ul style="list-style-type: none"> <li>• Fax the completed referral form Fax: <b>403-995-2619</b></li> </ul>	Within 1 week

The Rural Palliative Home Care Consult Team provides services to Home Care patients or to patients that have been admitted to a rural acute care facility. All requests (Rural North and Rural South) for Rural Palliative Consult Team should be faxed to the Rural office. The referral will be sent to the appropriate consult team member. You may be contacted to discuss the patient further with an option of a join visit. If you have not been contacted within 48 hours, please call the office to inquire regarding the consult.

If the consult is urgent, please call the office (an urgent referral is appropriate if the patient is at risk of presenting to the Emergency Department within 24 hours with palliative symptom issues). Please note we are not an emergency service. Our goal is to provide care in an appropriate setting depending on the patient's condition.

### What to expect from a Palliative Consultation:

The completed Consultation Note with recommendations will be faxed to the patient's Community Care Coordinator to be placed in the working file. The consultation note will also be sent to appropriate health care professionals involved with the patient (e.g. ALS clinic, TBCC, family physician, etc). Please note that Palliative Care Consultants will not assume responsibility of care for any patients. The consultants work with the patient's current medical providers in a specialized and consultative role to better support the patient/family.

### Additional information to be included with your referral:

- Paris ID# (if available)
- Indicate whether the family physician and patient is aware of the referral
- Indicate the Home Care Coordinator
- Include names, relationships and contact information for all primary support people
- Marital status
- Indicate who the person lives with:  
lives alone spouse family member other: \_\_\_\_\_
- Indicate the type of residence: and provide directions to it:  
DAL/PAL Group Home Personal Care Home  
Private Home Lodge Hospice
- Pharmacy name & contact information
- Any financial benefits/barriers (Blue Cross, AISH, DVA, other:\_)

- Indicate whether primary diagnosis is cancer or non-cancer
- Reason for consult should be one of the following:
  - Complex pain and symptoms
  - Transition to alternate settings of care (i.e. hospital, hospice, home)
  - Psychosocial or spiritual distress for person or family
  - Education needs of the person or family
  - Difficult end of life decision making
  - Coordination of resources
  - Deteriorating physical or cognitive function
- Brief medical history and summary of care needs (dressings, tubes/drains, stomas, oxygen, etc...)
- Indicate if there is a goals of care designation order or personal directive
- Language spoken and if an interpreter is required
- Describe any other psychosocial or cultural/religious considerations

- Indicate which community the patient is in:  
Airdrie, Banff, Black Diamond, Canmore, Carmangay, Chestermere, Claresholm, Cochrane, Didsbury, High River, Nanton, Okotoks, Strathmore, Vulcan, Other \_\_\_\_\_

## Urban Palliative Consult Team

403-944-2304

Triage Category	Includes	Process	Approximate time to be seen
<b>Emergent</b>	<ul style="list-style-type: none"> <li>• Patient is actively dying requiring emergent pain/symptom management intervention</li> <li>• Family/Patient support</li> </ul>	<ul style="list-style-type: none"> <li>• Phone office then fax the completed referral form Phone: <b>403-944-2304</b> Fax: <b>403-270-9652</b></li> </ul>	Same day (if an in-person visit isn't possible then a phone consult will be provided)
<b>Urgent</b>	<ul style="list-style-type: none"> <li>• Death is imminent and there is a great need of pain/symptom management</li> <li>• Family/Patient support</li> </ul>	<ul style="list-style-type: none"> <li>• Phone office then fax the completed referral form Phone: <b>403-944-2304</b> Fax: <b>403-270-9652</b></li> </ul>	Within 24 hours (if an in-person visit isn't possible then a phone consult will be provided)
<b>Semi-Urgent</b>	<ul style="list-style-type: none"> <li>• Pain/symptom management</li> <li>• Family/Patient support</li> <li>• Cognitive/Functional deterioration</li> </ul>	<ul style="list-style-type: none"> <li>• Fax the completed referral form Fax: <b>403-270-9652</b></li> </ul>	Within 48 hours
<b>Routine</b>	<ul style="list-style-type: none"> <li>• Family/Patient support</li> <li>• End of Life Decision Making</li> </ul>	<ul style="list-style-type: none"> <li>• Fax the completed referral form Fax: <b>403-270-9652</b></li> </ul>	Within 1 week

The Palliative Home Care Consult Team works with patients that are currently on Home Care (exceptions are made by the team). All requests for Palliative Home Care Consult should be faxed to the Urban Palliative Care Office to be triaged. The referral will be sent to the appropriate consult team member. You may be contacted to discuss the patient further with an option of a joint visit. If you have not been contacted within 48 hours, please call the office to inquire regarding the consult.

If the consult is urgent, please call the office (an urgent referral is appropriate if the patient is at risk of presenting to the Emergency Department within 24 hours with palliative symptom issues). Please note we are not an emergency service. Our goal is to provide care in an appropriate setting depending on the patient's condition.

### What to expect from a Palliative Consultation:

The completed Consultation Note with recommendations will be faxed to the patient's Community Care Coordinator to be placed in the working file. The consultation note will also be sent to appropriate health care professionals involved with the patient (e.g. ALS clinic, TBCC, family physician, etc). Please note that Palliative Care Consultants will not assume responsibility of care for any patients. The consultants work with the patient's current medical providers in a specialized and consultative role to better support the patient/family.

### Additional information to be included with your referral:

- Paris ID# (if available)
- Indicate whether the patient is aware of the referral
- Indicate whether the family physician is aware of the referral
- Indicate the Home Care Coordinator
- Indicate the type of residence:  
DAL/PAL                      Group Home      Personal Care Home  
Private Home                  Lodge                  Hospice
- Indicate who the person lives with:  
lives alone    spouse    family member    others: \_\_\_\_\_

- indicate whether primary diagnosis is cancer or non-cancer
- Reason for consult should be one of the following:
  - new diagnosis
  - pain management
  - deteriorating physical or cognitive function
  - symptom management
  - psychosocial distress for person or family
  - spiritual distress for person or family
  - coordination of care
  - education needs of the person or family
  - end of life decision making



## Infant Cranial Remodeling Program/Head Shape Clinic 403-955-5437

Triage Category	Examples	Process	Approximate time to be seen
<b>Urgent</b>	<ul style="list-style-type: none"> <li>Suspected craniosynostosis</li> </ul>	<ul style="list-style-type: none"> <li>Mail or fax referral to Head Shape Clinic <b>403-955-7609</b></li> <li>The referral will be redirected to Neurosurgical Clinic as appropriate.</li> </ul>	Within 2-4 weeks
<b>Semi Urgent</b>	<ul style="list-style-type: none"> <li>Infants eight to twelve months of age with plagiocephaly /brachycephaly/ dolichocephaly</li> </ul>	<ul style="list-style-type: none"> <li>Mail or fax referral to Head Shape Clinic <b>403-955-7609</b></li> </ul>	Within 4 weeks
<b>Routine</b>	<ul style="list-style-type: none"> <li>Infants four to eight months of age with plagiocephaly /brachycephaly/ dolichocephaly</li> </ul>	<ul style="list-style-type: none"> <li>Mail or fax referral to Head Shape Clinic <b>403-955-7609</b></li> </ul>	Triage to EIT or PA clinic according to age within four to six weeks of receipt of referral
<b>Routine</b>	<ul style="list-style-type: none"> <li>Infants &lt; four months of age with plagiocephaly /brachycephaly/ dolichocephaly</li> </ul>	<ul style="list-style-type: none"> <li>Mail or fax referral to Head Shape Clinic <b>403-955-7609</b> or parents may call to register for an Infant Repositioning Class</li> </ul>	Less than 1 month

The Infant Cranial Remodeling Program/Head Shape Clinic offers assessment and treatment of plagiocephaly, brachycephaly, dolichocephaly, and craniosynostosis for infants newborn to twelve months of age. The clinic structure is as follows:

- Pediatrician Assessment (PA) Clinic: infants 6-12 months of age
- Early Identification and Treatment (EIT) Clinic: infants 4-6 months of age are seen by a Physical Therapist or Occupational Therapist.
- Infant Repositioning Class: infants under 4 months of age. Referral to the clinic is not necessary; however for all referrals received for this age group, it will be mandatory to attend class prior to being seen in the PA or the EIT Clinics. Infants will be all be seen and assessed by an OT or PT.

### Service Transition

- Children seen in Infant Repositioning classes may be followed up in EIT or discharged and redirected back to their referral source
- Children seen in Infant Repositioning classes who are identified with torticollis are referred to Child Health or Community Physical Therapy services for follow-up
- Children seen in Head Shape Clinic are referred for treatment with a cranial remodeling device, referred back to Neurosurgery Clinic as appropriate or transitioned back to their referral source for ongoing follow-up

### Referral Process

Relevant information to be included with the referral:

- The specific head shape concern for which the infant is being referred
- Any concurrent diagnoses (including, but not limited to, torticollis and/or developmental delay)
- Date of birth
- Whether or not the infant was born at term
- The results of any imaging that may have been completed
- Scaphocephaly (dolichocephaly)/plagiocephaly/brachycephaly severity assessment score (optional) - developed by Cranial Technologies Inc. and downloadable off their website at [www.cranialtech.com](http://www.cranialtech.com)

### Contact Information for the Head Shape Clinic/ Infant Repositioning Classes

Head Shape Clinic, Neurosciences Program, Alberta Children's Hospital

2666 Shaganappi Trail NW Calgary, AB T3B 6A8

Telephone: 403-955-5437

Fax: 403-955-7609

Triage Category	Examples	Process	Approximate time to be seen
<b>Urgent</b>	<ul style="list-style-type: none"> <li>Acute neurological deterioration</li> <li>New onset infantile spasms or infantile epilepsy</li> <li>Suspected stroke or TIA</li> <li>New onset headache with suspected increased intracranial pressure</li> <li>Myasthenic crisis or unstable neuromuscular disease</li> <li>Guillain Barre</li> </ul>	<p>If you have a patient you believe needs to be seen urgently, please contact the pediatric neurologist on-call through the ACH operator <b>403-955-7211</b></p> <p>These referrals are NOT ACCEPTED BY FAX</p>	Within 1 week
<b>Semi Urgent</b>	<ul style="list-style-type: none"> <li>Deteriorating multiple sclerosis</li> <li>New onset epilepsy</li> <li>New onset movement disorder</li> <li>Severe intractable headache</li> <li>Progressive neurodegenerative condition</li> <li>Stable myasthenic disease</li> <li>Acute neuropathy</li> </ul>	<p>Referral received by fax or telephone or by internal direct department referral (DDR). Reviewed daily Monday-Friday by nurse and pediatric neurologist.</p> <p>Physicians are encouraged to send these referrals by fax. Fax: <b>403-955-7609</b></p>	Within 1 month
<b>Routine</b>	All other neurological concerns.	<p>Referral received by fax, by mail or sent by DDR. Fax: <b>403-955-7609</b></p> <p>Reviewed within 72 hours Monday-Friday by nurse and pediatric neurologist.</p>	3 months

### Service Description

The Neurology Program provides assessment, diagnosis, treatment and transition planning for children from birth to 18 years of age who have neurological disorders in collaboration with the community physicians. These include seizures, epilepsy, debilitating headache disorders including migraines, neuromuscular diseases, movement disorders, brain injury and stroke. The Neurology Program operates as a consultative or shared-care model. We do not provide primary care services. All referrals must have a family doctor/pediatrician or been referred to one. We encourage physicians to call for advice and support for any child with a neurological disorder.

### Relevant information to be included with the referral:

- Name of responsible primary care physician/pediatrician.
- The specific question or concern for which you believe this child needs to be seen by a neurologist.
- Comprehensive history and physical examination details.
- Any abnormal neurological findings (including developmental screening information).
- Latest lab work & any that have been ordered.
- List of current medications.
- Whether the patient has had, or booked for, any of the following: CT, MR or EEG. If yes, please indicate location and time.
- Whether this patient is followed through/or been referred to any other ACH specialty clinics. If yes, please indicate which ones.
- Please note: headache referrals enter a screening process. Usually only atypical headache disorders, worrisome headaches or debilitating headaches will be accepted. When referrals are not accepted, the physician and patient will be notified and helpful information will be provided.

### Exclusion Criteria

The following referrals will NOT be routinely accepted to the Neurology Clinic:

- Global developmental delay - unless referred by a pediatrician
- First seizures in children over 1 year of age
- Febrile convulsions
- Atypical febrile convulsion - unless seen & referred by a pediatrician
- Non-debilitating headaches
- Syncope or fainting spells
- Breath-holding spells
- Self-stimulatory behaviors

## Neuromotor Program

403-955-5437

Triage Category	Including, but not limited to:	Process	Approximate time to be seen
<b>Emergent</b>	<ul style="list-style-type: none"> <li>Children and families requiring urgent psychosocial support</li> <li>Child experiencing sudden onset of pain</li> <li>Children experiencing acute feeding issues</li> </ul>	<ul style="list-style-type: none"> <li>Mail or fax referral to Neuromotor Program Co-coordinator <b>403-955-7609</b></li> <li><b>A physician referral is required.</b></li> </ul>	Family will be contacted upon receipt of referral
<b>Urgent</b>	<ul style="list-style-type: none"> <li>Child experiencing pain</li> <li>Child and families who have a need for and do not have any supports in place (i.e. equipment, respite, funding supports, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>Mail or fax referral to Neuromotor Program Co-coordinator <b>403-955-7609</b></li> <li><b>A physician referral is required.</b></li> </ul>	Family will be contacted within 2 weeks of receipt of referral
<b>Semi Urgent</b>	<ul style="list-style-type: none"> <li>Children and families new to the province without required equipment or connections to community resources (e.g. PUF programs)</li> <li>Children experiencing a significant change in function</li> </ul>	<ul style="list-style-type: none"> <li>Mail or fax referral to Neuromotor Program Co-coordinator <b>403-955-7609</b></li> <li><b>A physician referral is required.</b></li> </ul>	Family will be contacted within 4 weeks of receipt of referral
<b>Routine</b>		<ul style="list-style-type: none"> <li>Mail or fax referral to Neuromotor Program Co-coordinator <b>403-955-7609</b></li> <li><b>A physician referral is required.</b></li> </ul>	Family will be contacted within 6 weeks of receipt of referral

The Neuromotor Program offers assessment, treatment, care co-ordination and counseling for children from birth to 18 years of age with a neuromotor diagnosis such as cerebral palsy (CP). Consultations with professional services are available through the program and include Pediatrics, Orthopedic Surgery, Nursing, Physical Therapy, Occupational Therapy, Speech and Language Pathology, Psychology, Social Work and Clinical Nutrition.

### Service Transition

- Therapists will facilitate transition of children and families into community-based services and/or school-based services as appropriate.
- Transition to adult services will commence at 16 years of age.
- A re-referral to the program is required every 2 years.

### Referral Process

Referrals to the program can be made using the Internal Referral Form. A physician referral is required.

Relevant information to be included with the referral:

- Specific identified issue(s) or problem(s)
- Date of birth
- Birth record
- Diagnosis and concurrent diagnoses
- That a discussion of diagnosis of cerebral palsy or of cerebral-palsy like condition has occurred with the family
- Results of any developmental screening
- Results of any diagnostic imaging
- Surgical history
- History of botox injections
- Other clinics and services involved in the child's care
- Previous reports including therapy reports
- Language spoken in the home, including whether the parents speak English
- Equipment, splinting, bracing
- Current address, phone number and names of caregivers/guardians
- Medications
- Healthcare coverage

### Contact Information Neuromotor Program

Neuromotor Program, Neurosciences Program, Alberta Children's Hospital  
2666 Shaganappi Trail NW Calgary, AB T3B 6A8 Telephone: 403-955-5437

Fax: 403-955-7609

## Neuromuscular Program

403-955-7603

Triage Category	Including, but not limited to:	Process	Approximate time to be seen
<b>Urgent</b>	<ul style="list-style-type: none"> <li>Children experiencing acute feeding issues</li> <li>Children and families requiring urgent psychosocial support</li> <li>New diagnosis presenting with functional concerns and no existing therapy support in place</li> </ul>	<ul style="list-style-type: none"> <li>Mail or fax referral Neuromuscular Program <b>403-955-7609</b></li> <li><b>A physician referral is required.</b></li> </ul>	<ul style="list-style-type: none"> <li>Family will be contacted upon receipt of referral</li> <li>Wait time ranges from days up to four weeks depending on identified issues</li> </ul>
<b>Routine</b>	<ul style="list-style-type: none"> <li>Children experiencing change in functional status (e.g. increased falls, difficulty with ADLS, change in equipment needs, including splinting)</li> <li>Children requiring monitoring of developmental status in the absence of community services</li> </ul>	<ul style="list-style-type: none"> <li>Mail or fax referral Neuromuscular Program <b>403-955-7609</b></li> <li><b>A physician referral is required.</b></li> </ul>	<ul style="list-style-type: none"> <li>Family will be contacted within two weeks of receipt of referral</li> <li>Appointment to be scheduled within six weeks depending on identified issues</li> </ul>

The Neuromuscular Program offers diagnosis, assessment, treatment, care co-ordination, and counseling for children from birth to 18 years of age with a neuromuscular diagnosis such as muscular dystrophy, myotonic dystrophy, spinal muscular atrophy, and Charcot-Marie-Tooth.

Professional services available within the program include Neurology/Pediatrics, Orthopedic Surgery, Pulmonology, Nursing, Physical Therapy, Occupational Therapy, Psychology, and Social Work. Consultations can be made to Cardiology, Sleep Lab, Speech-Language Pathology, and Clinical Nutrition as required.

### Service Transition

Therapists will facilitate transition of children and families into community-based rehab services and/or school-based services as appropriate.

Clinic-based therapists liaise with community therapists (e.g. school board therapists, home care, rural therapy agency, etc.) regarding relevant issues as identified through assessments and clinic visits.

### Referral Process

A physician referral is required.

Referrals can be made using the Internal Referral Form Relevant information to be included with the referral:

- Specific identified issue(s) or problem(s).
- Birth history
- Results of any diagnostic testing
- Surgical history
- Other clinics and services involved in the child's care
- Previous reports including therapy reports
- Language spoken in the home, including whether the parents speak English

### Contact Information Neuromuscular Program

Neuromuscular Program, Neurosciences Program, Alberta Children's Hospital

2666 Shaganappi Trail NW Calgary, AB T3B 6A8

Telephone: 403-955-5437

Fax: 403-955-7609

## Neuro Rehabilitation Program

Triage Category	Including, but not limited to:	Process	Approximate time to be seen
<b>Priority</b>	<ul style="list-style-type: none"> <li>Child requires out-patient therapy follow-up to support discharge from an inpatient setting</li> </ul>	<ul style="list-style-type: none"> <li>Mail or fax referral Neuro Rehabilitation Program <b>403-955-2620</b></li> </ul>	<ul style="list-style-type: none"> <li>Within one week of discharge</li> </ul>
<b>Routine</b>	<ul style="list-style-type: none"> <li>Child's performance issues are significantly impacting school or home functioning</li> </ul>	<ul style="list-style-type: none"> <li>Mail or fax referral Neuro Rehabilitation Program <b>403-955-2620</b></li> </ul>	<ul style="list-style-type: none"> <li>Contacted within two weeks of receipt of referral</li> </ul>

The Neuro Rehabilitation Program provides assessment, treatment, care co-ordination, and counseling for children from birth to 18 years of age who have experienced an acute change in functioning due to illness, surgery, or injury (e.g. brain injury). Professional services available through the program include Neurology, Physiatry, Nursing, Physical Therapy, Occupational Therapy, Speech and Language Pathology, Child Life/Recreation Therapy, Psychology, Education Consultation and Social Work.

### Service Transition

If required, children transition to receiving medical follow-up in other neuroscience clinics two years post acute event. Children transition from this service to community/school based rehabilitation services when their needs can be appropriately met there.

### Referral Process

- Children requiring therapy services can be referred to the program by any healthcare provider or team
- Children requiring medical follow-up in the Brain Injury Clinic require a physician's referral
- Referrals can be made using the Internal Referral Form. relevant information to be included with the referral:
- Description of presenting concern/specific issue or problem to be addressed
- Concurrent diagnoses
- Inpatient admission history
- Surgical history if applicable
- Results of any diagnostic imaging
- Other clinics and/or services involved in the child's care
- Previous reports including therapy reports
- Language spoken in the home, including whether the parents speak English

### Contact Information for the Neuro Rehabilitation Program

Neuro Rehabilitation Program, Neurosciences Program, Alberta Children's Hospital  
2666 Shaganappi Trail NW Calgary, AB T3B 6A8

Neuro Rehabilitation Program Co-coordinator:

Telephone: 403-955-2603 (for children registered in school)  
403-955-7063 (for children registered in pre-school)

Fax: 403-955-2620

Brain Injury Clinic:

Telephone: 403-955-7900  
Fax: 403-955-2620



## Hepatopancreaticobiliary (HPB)

Dr. Bathe 403-521-3179  
 Dr. Dixon 403-944-3045  
 Dr. Sutherland 403-944-1233

Triage Category	Includes	Process	Approximate time to be seen
<b>Emergent</b>	<ul style="list-style-type: none"> <li>Complete obstruction</li> <li>Ascending cholangitis or bleeding from tumor of pancreas, liver, or biliary system</li> </ul>	<ul style="list-style-type: none"> <li>Page Hepatopancreaticobiliary (HPB) surgeon on call <b>403-944-1110</b></li> </ul>	Same day (emergency)
<b>Urgent</b>	<ul style="list-style-type: none"> <li>Severe acute pancreatitis with necrosis (AP)</li> <li>Newly diagnosed lesion, tumor or masses (suspicious for cancer) of the liver, pancreas, bile ducts or gallbladder</li> <li>Complicated pancreatitis</li> <li>Complicated gallstone disease</li> <li>Any cystic lesions of the liver, pancreas, duodenum, bile ducts</li> <li>Any biliary strictures</li> <li>Obstructive jaundice</li> <li>Liver metastases of any origin that require assessment for ablative treatments or resection</li> <li>Traumatic or iatrogenic injuries to the bile duct, liver, or pancreas</li> </ul>	<ul style="list-style-type: none"> <li>Fax Hepatopancreaticobiliary (HPB) referral to triage line: <b>403-476-8798</b></li> </ul>	Within 2 weeks
<b>Routine</b>	<ul style="list-style-type: none"> <li>Chronic pancreatitis and benign diseases of liver, pancreas, and biliary system</li> </ul>	<ul style="list-style-type: none"> <li>Fax referral to Hepatopancreaticobiliary (HPB) triage line: <b>403-476-8798</b></li> </ul>	Within 6 weeks

**\*\*NOTE: Non-neoplastic conditions of the gallbladder (biliary colic, acute cholecystitis) should NOT be sent to the Hepatopancreaticobiliary (HPB) triage line.**

**Specific co-morbidity information to identify if relevant:**

- Provide all considered relevant by the referring source.

**Specific symptom information to identify if relevant:**

- Provide all considered relevant by the referring source.

**Providing the following relevant information (if available) will expedite care of your patient:**

- Bloodwork (CBC, electrolytes, creatinine, PT, PTT, ALT, Alk Phos, T-Bili, GGT, Lipase)
- Copy of all biopsy results
- Tumor Markers where appropriate- CEA, CA19-9, alpha fetoprotein
- Hepatitis serology where appropriate (hepatoma patients)
- Copy of all endoscopy and other interventional reports
- Copy of all imaging results and for patients not imaged on Calgary PACS system (FMC, PLC, RGH, Sheldon Chumir, South Calgary, High River, Canmore) a copy of MRI and/or CT scan on CD



## Calgary Breast Health Clinic

403-944-2240

Triage Category	Examples	Process	Approximate time to be seen
<b>Urgent</b>	<ul style="list-style-type: none"> <li>Confirmed or suspected breast cancer</li> <li>Abnormal diagnostic imaging suggestive of malignancy*</li> <li>Suspicious clinical exam</li> <li>Inflammatory changes to the breast</li> <li>Breast abscess requiring I&amp;D</li> </ul>	<ul style="list-style-type: none"> <li>Fax referral to: <b>403-944-2250</b></li> <li>Call: <b>403-944-2240</b> for guidance if required</li> </ul>	Within 2 weeks
<b>Semi Urgent</b>	<ul style="list-style-type: none"> <li>Solid persistent mass with benign features on diagnostic imaging</li> <li>Abnormal imaging requiring further investigations, likely benign</li> <li>Complex cysts</li> <li>Nipple discharge: spontaneously bloody, clear unilateral</li> <li>Atypical pathology on core biopsy requiring surgical consult</li> </ul>	<ul style="list-style-type: none"> <li>Fax referral to: <b>403-944-2250</b></li> </ul>	Within 3 weeks
<b>Routine</b>	<ul style="list-style-type: none"> <li>Mastalgia</li> <li>Fibrocystic breasts</li> <li>Bilateral nipple discharge</li> <li>Family History</li> <li>Prophylactic mastectomy</li> <li>Worried patient with negative workup seeking second opinion from surgeon and teaching from nurse</li> </ul>	<ul style="list-style-type: none"> <li>Fax referral to: <b>403-944-2250</b></li> </ul>	Within 4 weeks

### Specific tests/investigations required to enable triage:

All mammogram, ultrasound or relevant pathology reports should be faxed with the referral.

Patient to bring imaging films to initial appointment.

\*Suspicious clinical exams and/or suggestive diagnostic findings should be referred urgently. Diagnostic mammograms will be expedited through the clinic.

## Colposcopy Program

403-944-2205

Triage Category	Examples	Process	Approximate time to be seen
<b>Urgent</b>	<ul style="list-style-type: none"> <li>• PAP smear Squamous Cell Carcinoma</li> <li>• PAP Adenocarcinoma</li> <li>• PAP Other Malignant types</li> </ul>	<ul style="list-style-type: none"> <li>• Fax referral to: <b>403-944-2250</b></li> </ul>	Within 1-2 weeks
<b>Semi Urgent</b>	<ul style="list-style-type: none"> <li>• ASC - H Atypical Squamous Cell- cannot exclude HSIL</li> <li>• HSIL - High Grade Squamous intraepithelial lesion (CIN 2-3)</li> <li>• Atypical Glandular cell Adenocarcinoma in Situ</li> <li>• Abnormal appearing cervix regardless of PAP smear findings</li> </ul>	<ul style="list-style-type: none"> <li>• Fax referral to: <b>403-944-2250</b></li> </ul>	Within 2 month
<b>Routine</b>	<ul style="list-style-type: none"> <li>• LSIL- Low Grade Squamous cells of undetermined significance – 2 PAP smears at least 6 months apart over 2 years</li> <li>• ASCUS- Low Grade - 2 PAP smears at least 6 months apart over 2 years</li> <li>• Lesions</li> <li>• Genital warts</li> <li>• Post-coital bleeding</li> <li>• Under Age 21- 3 abnormal paps 1 year apart unless high grade then seen semi urgently</li> </ul>	<ul style="list-style-type: none"> <li>• Fax referral to: <b>403-944-2250</b></li> </ul>	Within 4 -5 months

**NOTE:**

Colposcopy is a diagnostic service

Please phone referrals to 403-944-2205

**Pregnancy and Abnormal Pap**

- High Grade seen on initial referral up to 7 months
- If over 7 months, see at least 3 months post partum
- Low Grade not seen until 6 months post partum

**Specific tests/investigations required to enable triage:****Relevant co-morbidities:**

- Previous genital warts
- Infectious disease- sexually transmitted agents
- Any other concurrent medical problems
- Therapeutic abortion, D & C or Ablation within the last 4 weeks

**Relevant physical and history such as:**

- Abnormal looking cervix
- Abnormal vaginal bleeding
- Other relevant information

**Specific tests or investigations:**

- Histopathology reports for any surgical procedures, biopsy, or cytology including PAP smear
- History & Physical
- Any relevant DI reports
- All relevant Consultation reports

## High Risk Breast Cancer Clinic

403-944-2444

Triage Category	Examples	Process	Approximate time to be seen
<b>Routine</b>	All referrals are considered routine, but wait time is dependant upon the services required and completion of the telephone interview/history with the RN	Fax all referrals to <b>403-944-8614</b> And include the items below	2-4 weeks
<b>Offered next available Appointment with HRBCC team (MD, RN &amp; Psychologist)</b>	Pre-cancerous conditions e.g. Lobular Carcinoma in Situ (LCIS) or Atypical Hyperplasia (ADH,ALH)	Include pathology report	
	Mantle radiation < age 30	Include oncology report, or provide the name of the treating cancer centre	
	Medical genetics testing in the family has: <ul style="list-style-type: none"> <li>Confirmed a mutation</li> <li>Been non-informative</li> <li>Been offered but appropriate person to test is not alive or available i.e. family history has been assessed and confirmed by a geneticist</li> </ul>	Include genetics letter or copy of genetic test	
	5 year breast cancer risk of 1.7% or greater (modified Gail) wishing to discuss tamoxifen/ raloxifene	(We use <a href="http://www.cancer.gov/bcrisktool">www.cancer.gov/bcrisktool</a> )	
<b>Internal triage and possible referral directly to clinical genetics</b>	Client reports multiple cases of cancer (including breast or ovarian) in her family	Provide details on fax: e.g. Paternal Aunt Dx breast @35, Died @40 Send relative's pathology reports if at all possible	3-6 weeks
<b>Referral to team Psychologist Only</b>	Client is aware of her own or a family member's high-risk status and is having difficulty with decision making, communicating with family, or experiencing anxiety or depression related to risk	Please indicate "Psychosocial referral only" on the referral form	10-14 days

We are reluctant to see clients in active treatment for cancer, as their risk for metastases from their current disease is often much higher than a new primary. However if a client has a specific question that cannot be answered by their cancer-care team please call the clinic nurse for assistance.

Specific tests/investigations required to enable triage: As above

## Pelvic Floor Clinic

403-944-4000

Triage Category	Examples	Process	Approximate time to be seen
<b>Urgent</b>	<ul style="list-style-type: none"> <li>• Complete prolapse of vagina, causing obstruction of urethra and inability to void</li> <li>• Sudden bleeding or infection of vaginal tissues as a result of a “forgotten” or impacted pessary</li> <li>• Postpartum patients with fourth degree anal sphincter tears</li> </ul>	If complete retention, require indwelling catheter and care initially. <b>Phone 403-944-4000</b>	2-3 weeks
<b>Routine</b>	<ul style="list-style-type: none"> <li>• Urinary incontinence of all types (stress, urge, overflow)</li> <li>• Bowel evacuation dysfunction including anal incontinence or constipation</li> <li>• Pelvic Organ Prolapse (vaginal bulging or heaviness)</li> <li>• Those having had previous surgical interventions by clinic physicians with ongoing or new issues</li> <li>• Referrals for only urodynamic testing (accepted from gynecologists and urologists only)</li> <li>• Referrals for ARPs (from GI specialists and colorectal surgeons only)</li> <li>• Recurrent UTIs (urine cultures must be attached)</li> </ul>	For most new referrals, initial appointment consists of an education session  <b>Fax referral to Pelvic Floor Clinic 403-944-2154</b>	2-4 weeks for education session  4-6 months for clinic appointment

Information required to enable triage: Specific type of disorder (eg. Type of incontinence, prolapse, etc)  
 Previous treatment or surgical intervention for these issues.



## Oncologic Emergency Guidelines

Cancer patients are at risk for medical emergencies. These acute events may arise either from the tumour itself, to the treatment given to control the tumour or it may be related to a new or previously existing condition not related to cancer. Because such conditions may require emergency treatment, the recognition of these emergencies at the earliest stage is critical as it improves outcomes. These triaging guidelines should therefore be familiar to all TBCC clinical and non-clinical staff that are involved in triaging new TBCC cancer patients, either in person or through the patient referral process. A one page summary of these guidelines is provided in Appendix C for use as a reference tool by triage clinicians.

### Superior Vena Cava Syndrome

<b>Presenting features/symptoms</b>	<ul style="list-style-type: none"> <li>• Clinical findings that indicate possible emergency:                             <ul style="list-style-type: none"> <li>◦ New/progressive neck/facial/arm swelling, often with associated dilated chest and neck veins, progressive shortness of breath including shortness of breath while lying down or bending forward</li> <li>◦ Especially concerning if associated with proptosis (bulging eyes), stridor (noise on breathing inward), tongue swelling or drowsiness</li> </ul> </li> <li>• Often associated with several other symptoms, related to tumour in chest</li> <li>• May be identified solely on CT chest report as tumour causing compression of superior vena cava, even in the absence of clinical description of poor patient status within the referral documentation</li> </ul>
<b>Reason for urgency</b>	<ul style="list-style-type: none"> <li>• Without treatment, average survival in patients with Superior Vena Cava Syndrome due to cancer is about 1 month.</li> </ul>
<b>Associated tumour type/s</b>	<ul style="list-style-type: none"> <li>• Lung cancer and lymphoma are the 2 most common malignant causes of Superior Vena Cava Syndrome, but any type of cancer cause it.</li> </ul>
<b>Action</b>	<ul style="list-style-type: none"> <li>• If not already done, CT chest with contrast (should be ordered by referring physician).</li> </ul>
<b>Management</b>	<ul style="list-style-type: none"> <li>• Triage clinician discuss patient with on-call Radiation Oncologist to confirm emergency</li> <li>• If situation is identified as an emergency, Radiation Oncologist decides whether to:                             <ul style="list-style-type: none"> <li>◦ advise the patient to go to the Emergency Department</li> <li>◦ organize emergency/urgent consult in TBCC</li> <li>◦ organize further test(s)</li> <li>◦ talk to the referring / family physician</li> </ul> </li> <li>• The decision should be documented on the referral form and the documentation transferred to TBCC physician.</li> </ul>

## Spinal Cord Compression (SCC)

<b>Presenting features/symptoms</b>	<ul style="list-style-type: none"> <li>• <b>Pain:</b> Back pain is usually the first symptom of SCC; it is often constant, dull, aching and sometimes radiating. The pain may progress slowly or quickly (crescendo pain, each day worse than the previous). It is exacerbated by movement, especially when flexing the neck or raising the legs, coughing, sneezing, or straining. Leg pain may occur and be unilateral or bilateral radiating from the back.</li> <li>• <b>Motor Weakness:</b> This usually follows pain. Patients may experience stiffness and heaviness of the affected extremity, they may present with an unsteady gait or ataxia and foot drop.</li> <li>• <b>Sensory Impairment:</b> This usually follows pain; symptoms include loss of sensation, numbness, tingling, pins and needles type feeling and coldness in the affected area.</li> <li>• <b>Autonomic dysfunction:</b> Loss of bladder control results in urinary retention, frequent small voids, overflow or incontinence. Loss of bowel control such as the urge to defecate, may lead to constipation or incontinence. Loss of sphincter control is often a later sign that is associated with a poor prognosis. Sexual impotence may also manifest.</li> </ul>
<b>Reason for urgency</b>	<ul style="list-style-type: none"> <li>• Without identification and a delay in the appropriate treatment, complete and irreversible paraplegia may develop within hours to days.</li> </ul>
<b>Associated tumour type/s</b>	<ul style="list-style-type: none"> <li>• Includes any cancer. Most common are lung, breast and prostate.</li> </ul>
<b>Action</b>	<ul style="list-style-type: none"> <li>• MRI of the affected area provides the best definition of spinal lesions and is the procedure of choice.</li> <li>• The goal of treatment is for pain relief, restoration of any neurological deficits, stabilization of the spinal cord and tumour control. Treatment depends on the type of tumour, its location, the speed of onset, the level and severity of the compression and the patient's functional level before the onset of symptoms. Treatment in the early stages of SCC is usually effective and includes the following:             <ul style="list-style-type: none"> <li>◦ Radiation therapy is the standard treatment; it resolves pain by decreasing the tumour mass which relieves the SCC. Patients may experience relief of their symptoms within days of starting the therapy and pain is sometimes relieved within hours of commencement.</li> <li>◦ Corticosteroid therapy (dexamethasone) is given to decrease the edema and cord compression caused by the tumour thus assisting in relieving the patient's pain. It may also assist in improving neurological function.</li> <li>◦ Decompressive surgery (laminectomy) with or without stabilization may be considered for patients with rapidly progressing neurological deficits, the inability or failure to respond to radiotherapy or a pathological fracture that is causing instability or compression to the spinal cord.</li> <li>◦ Chemotherapy is occasionally used in patients with chemo sensitive tumours such as Hodgkin's disease or lymphoma.</li> </ul> </li> </ul>
<b>Management</b>	<ul style="list-style-type: none"> <li>• Triage clinician discuss patient with on-call Radiation Oncologist to confirm emergency</li> <li>• If situation is identified as an emergency, Radiation Oncologist decides whether to:             <ul style="list-style-type: none"> <li>◦ Advise the patient to go to the Emergency Department</li> <li>◦ Organize emergency/urgent consult in TBCC</li> <li>◦ Organize further test(s)</li> <li>◦ Talk to the referring /family physician</li> </ul> </li> <li>• The decision should be documented on the referral form or patient chart and the documentation transferred to TBCC physician.</li> </ul>

## Electrolyte abnormalities

<b>Presenting features/symptoms</b>	<ul style="list-style-type: none"> <li>• Most commonly, electrolyte abnormalities are identified by lab tests</li> <li>• Patients may have an altered level of consciousness</li> <li>• Nausea /vomiting</li> <li>• Profound weakness</li> </ul>
<b>Reason for urgency</b>	<ul style="list-style-type: none"> <li>• Left untreated condition will result in severe dehydration, renal failure, neurological symptoms including coma leading to death, heart rhythm problems and other life threatening problems.</li> </ul>
<b>Associated tumour type/s</b>	<ul style="list-style-type: none"> <li>• Lung (by far the most common)</li> <li>• Prostate</li> <li>• Kidney</li> <li>• ANY OTHER CANCER</li> </ul>
<b>Investigation</b>	<ul style="list-style-type: none"> <li>• Serum electrolytes, including calcium, magnesium and phosphorus, and serum creatinine, BUN</li> </ul>
<b>Management</b>	<ul style="list-style-type: none"> <li>• Triage clinician discuss patient with on call Medical Oncologist to confirm emergency</li> <li>• If situation is an emergency Medical oncologist decide whether to: <ul style="list-style-type: none"> <li>◦ Advise the patient to go to emergency</li> <li>◦ Organize an urgent consult</li> <li>◦ Organize further tests</li> <li>◦ Talk to the family physician</li> </ul> </li> <li>• The decision should be documented on the referral form and the documentation transferred/filed appropriately</li> </ul>

## Hypercalcemia

<b>Presenting features/symptoms</b>	<ul style="list-style-type: none"> <li>• Altered level of consciousness</li> <li>• Nausea/vomiting</li> <li>• Bone pain</li> </ul>
<b>Reason for urgency</b>	<ul style="list-style-type: none"> <li>• Condition results from disrupted calcium homeostasis</li> <li>• Left untreated condition will result in severe dehydration, renal failure, neurological symptoms including coma leading to death, etc.</li> </ul>
<b>Associated tumour type/s</b>	<p>Arises in ANY CANCER including but not limited to:</p> <ul style="list-style-type: none"> <li>• Breast</li> <li>• Lung</li> <li>• Kidney</li> <li>• Myeloma</li> <li>• Lymphoma</li> <li>• May result from bone metastases or paraneoplastic syndromes</li> </ul>
<b>Investigation</b>	<ul style="list-style-type: none"> <li>• Measure serum calcium and serum albumin</li> </ul>
<b>Management</b>	<ul style="list-style-type: none"> <li>• Triage clinician discuss patient with on call Medical Oncologist to confirm emergency</li> <li>• If situation is an emergency Medical oncologist decide whether to: <ul style="list-style-type: none"> <li>◦ Advise the patient to go to emergency</li> <li>◦ Organize an urgent consult</li> <li>◦ Organize further tests</li> <li>◦ Talk to the family physician</li> </ul> </li> <li>• The decision should be documented on the referral form and the documentation transferred/filed appropriately</li> </ul>

## Malignant Bowel Obstruction

<b>Presenting features/ symptoms</b>	<ul style="list-style-type: none"> <li>• Increased Abdominal Pain, often crampy and intermittent</li> <li>• Lack of bowel movement &gt;24h</li> <li>• Lack of ostomy movement &gt;8h</li> <li>• Nausea with vomiting, often bilious</li> <li>• Lack of feeling of bowel sounds or rumbling</li> <li>• May be associated with fever, tachycardia or peritoneal signs</li> </ul>	
<b>Reason for urgency</b>	<ul style="list-style-type: none"> <li>• Risk for perforation</li> <li>• Dehydration</li> <li>• Acute Renal Failure</li> <li>• Septic Shock</li> <li>• Ischemic gut</li> <li>• Peritonitis</li> </ul>	
<b>Associated tumour type/s</b>	<ul style="list-style-type: none"> <li>• Gastrointestinal               <ul style="list-style-type: none"> <li>◦ Gastric</li> <li>◦ Pancreatic</li> <li>◦ Cholangiocarcinoma</li> <li>◦ Small Bowel</li> <li>◦ Large Bowel</li> <li>◦ Gastrointestinal Stromal Tumours</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Ovarian</li> <li>• Breast</li> <li>• Lymphoma</li> <li>• Neutropenic conditions</li> <li>• Previous Abdominal Surgery</li> <li>• Hernia</li> </ul>
<b>Investigation</b>	<ul style="list-style-type: none"> <li>• 3 views Abdomen showing air fluid levels</li> <li>• CT Abdomen and /or abdominal ultrasound</li> </ul>	
<b>Management</b>	<ul style="list-style-type: none"> <li>• Triage Clinician to discuss with attending oncologist to confirm medical emergency</li> <li>• If situation is emergent, oncologist to determine whether to:               <ul style="list-style-type: none"> <li>◦ Advise patient to go to emergency</li> <li>◦ Consult on call surgeon directly</li> </ul> </li> <li>• The decision should be documented on the referral form and the documentation transferred/filed appropriately</li> </ul>	

## Raised Intracranial Pressure

<b>Presenting features / symptoms</b>	<ul style="list-style-type: none"> <li>• Clinical findings that indicate possible emergency:               <ul style="list-style-type: none"> <li>◦ New/progressive drowsiness or headache</li> </ul> </li> <li>• Often associated with several other symptoms, related to raised intracranial pressure, including nausea and vomiting, spells of impaired vision or hearing, or progressive weakness or numbness</li> </ul>
<b>Reason for urgency</b>	<ul style="list-style-type: none"> <li>• Without treatment, patients with raised intracranial; pressure are at risk of sudden death or permanent neurological impairment from herniation or ischemia</li> </ul>
<b>Associated tumour type/s</b>	<ul style="list-style-type: none"> <li>• Primary malignant brain tumors such as GBM, and multiple brain metastases such as breast, lung or melanoma, are most common causes</li> </ul>
<b>Action</b>	<ul style="list-style-type: none"> <li>• If not already done, CT scan of the head with or without contrast, and urgent assessment by a physician</li> </ul>
<b>Management</b>	<ul style="list-style-type: none"> <li>• Triage clinician discuss patient with on-call Radiation Oncologist or Medical Oncologist to confirm emergency</li> <li>• If situation is identified as an emergency, Oncologist decides whether to:               <ul style="list-style-type: none"> <li>◦ Advise the patient to go to the Emergency Department</li> <li>◦ Organize emergency /urgent consult in TBCC</li> <li>◦ Organize further test(s)</li> <li>◦ Talk to the referring /family physician</li> </ul> </li> <li>• The decision should be documented on the referral form and the documentation transferred to TBCC physician</li> </ul>

## Life-threatening Respiratory Difficulty

<b>Presenting features/symptoms</b>	<ul style="list-style-type: none"> <li>• Shortness of breath at rest or with minimal movement</li> <li>• Chest pain</li> </ul>
<b>Reason for urgency</b>	<ul style="list-style-type: none"> <li>• Patients can experience respiratory arrest and death</li> </ul>
<b>Associated tumour type/s</b>	<ul style="list-style-type: none"> <li>• Arises in ANY INVASIVE CANCER or any cancer associated with a blood clot</li> </ul>
<b>Investigation</b>	<ul style="list-style-type: none"> <li>• Differential diagnosis includes but not limited to pleural effusion, pulmonary embolus (PE), and cardiac tamponade. Obtain urgent CT chest with PE protocol. Chest x-ray or cardiac ultrasound can also be useful. Consider bloodwork including ABGs</li> </ul>
<b>Management</b>	<ul style="list-style-type: none"> <li>• Triage Clinician to discuss with attending oncologist to confirm medical emergency</li> <li>• If situation is emergent, oncologist to determine whether to:             <ul style="list-style-type: none"> <li>◦ Advise patient to go to emergency</li> <li>◦ Consult on call pulmonologist or internist directly</li> </ul> </li> <li>• The decision should be documented on the referral form and the documentation transferred/filed appropriately</li> </ul>

## Potential Upper Airway Obstruction

<b>Presenting features/symptoms</b>	<ul style="list-style-type: none"> <li>• Stridor (noise while breathing in or out); shortness of breath; a feeling of tightness in the throat or airway; even if asymptomatic, the presence of tumor that is known to be invading the upper airway or other vital neck structures (carotid artery etc)</li> </ul>
<b>Reason for urgency</b>	<ul style="list-style-type: none"> <li>• Partial occlusion of the upper airway is associated with the occurrence of sudden death</li> </ul>
<b>Associated tumour type/s</b>	<ul style="list-style-type: none"> <li>• Any malignancy invading upper airway structures, particularly: anaplastic thyroid; head and neck; lung cancer; others</li> </ul>
<b>Investigation</b>	<ul style="list-style-type: none"> <li>• Definitive imaging of the neck structures with either MRI or CT scan</li> <li>• Direct visualization with endoscopy or laryngoscopy.</li> </ul>
<b>Management</b>	<ul style="list-style-type: none"> <li>• Triage Clinician to discuss with attending oncologist to confirm medical emergency</li> <li>• If situation is emergent, oncologist to determine whether to:             <ul style="list-style-type: none"> <li>◦ Advise patient to go to emergency</li> <li>◦ Consult on call ENT surgeon or Respiriologist directly</li> </ul> </li> <li>• The decision should be documented on the referral form and the documentation transferred/filed appropriately</li> </ul>





**Addressograph or Label**

Patient Name: \_\_\_\_\_ Gender: \_\_\_\_\_  
AB Cancer Board Number: \_\_\_\_\_  
Personal Health Number: \_\_\_\_\_  
Date of Birth (y/m/d): \_\_\_\_\_  
Address: \_\_\_\_\_

**\* Referring Physician to complete section above  
and give form to your patient for completion**

**Alberta Blood and Marrow Transplant Program – Adult  
Family Human Leukocyte Antigen (HLA) Typing Referral Form**

**Spouse**

Please complete the following information about your spouse. If you have any questions or require additional copies of this form, please call the Tom Baker Cancer Centre – Blood and Marrow Transplant Clinic at (403) 521-3528 and ask for the Intake Registered Nurse.

**Spouse**  
First Name: \_\_\_\_\_  
Last Name: \_\_\_\_\_  
Gender: \_\_\_\_\_ Age: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City / Prov / Country: \_\_\_\_\_  
Postal Code: \_\_\_\_\_  
Telephone (H) \_\_\_\_\_  
(W) \_\_\_\_\_  
(C) \_\_\_\_\_  
Email address: \_\_\_\_\_  
Languages Spoken (indicate primary language):  
\_\_\_\_\_  
 Interpreter Required  
Is this person aware that he/she will be contacted by  
our office?  Yes  No  
Comments: \_\_\_\_\_  
\_\_\_\_\_

Please return completed form (with additional pages if required) either in the pre-addressed envelope provided within this information package or via the fax number provided below.

Please mail form to: Intake Team  
Tom Baker Cancer Centre  
Blood and Marrow Transplant Clinic  
1331 – 29<sup>th</sup> Street NW  
Calgary, AB T2N 4N2

or fax to: Attention: Intake Team  
(403) 270-0782



**Addressograph or Label**

Patient Name: \_\_\_\_\_ Gender: \_\_\_\_\_  
 AB Cancer Board Number: \_\_\_\_\_  
 Personal Health Number: \_\_\_\_\_  
 Date of Birth (y/m/d): \_\_\_\_\_  
 Address: \_\_\_\_\_

**\* Referring Physician to complete section above  
and give form to your patient for completion**

**Alberta Blood and Marrow Transplant Program – Adult  
Family Human Leukocyte Antigen (HLA) Typing Referral Form**

**Parents**

Please complete the following information about your biological parents currently alive. If you have any questions or require additional copies of this form, please call the Tom Baker Cancer Centre – Blood and Marrow Transplant Clinic at (403) 521-3528 and ask for the Intake Registered Nurse.

<b>Mother</b>	<b>Father</b>
First Name: _____	First Name: _____
Last Name: _____	Last Name: _____
Age: _____	Age: _____
Street Address: _____	Street Address: _____
City / Prov / Country: _____	City / Prov / Country: _____
Postal Code: _____	Postal Code: _____
Telephone (H) _____	Telephone (H) _____
(W) _____	(W) _____
(C) _____	(C) _____
Email address: _____	Email address: _____
Languages Spoken (indicate primary language): _____	Languages Spoken (indicate primary language): _____
<input type="checkbox"/> Interpreter Required	<input type="checkbox"/> Interpreter Required
Is this person aware that he/she will be contacted by our office? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this person aware that he/she will be contacted by our office? <input type="checkbox"/> Yes <input type="checkbox"/> No
Comments: _____ _____	Comments: _____ _____

Please return completed form (with additional pages if required) either in the pre-addressed envelope provided within this information package or via the fax number provided below.

Please mail form to: Intake Team  
 Tom Baker Cancer Centre  
 Blood and Marrow Transplant Clinic  
 1331 – 29<sup>th</sup> Street NW  
 Calgary, AB T2N 4N2

or fax to: Attention: Intake Team  
 (403) 270-0782

