Highland Primary Care Network
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HPCN Central Programs Referral Form

The Highland Primary Care Network (HPCN) offers a variety of programs centrally to support physicians and patients with their mental, social, and physical health. Please refer to the HPCN Program Overview document to help your decision making on which program is relevant for the patient. **Please note, incomplete forms will be returned.**

Patient Name: _____ Referral Date: _____

PHN: _____

DOB: _____ Referred By: _____

Address: _____

Phone: _____

Family Physician: _____

Parent/Guardian Name (if applicable): _____ Phone: _____

Referral Options:

☐ 7to7teen
☐ Ambulatory Blood Pressure (24 hr)
☐ Health Improvement Program (HIP)
☐ Allied Health Team (please choose provider):
☐ Chronic Pain
☐ Mental Health Triage
☐ Dietitian
☐ Kinesiologist

Provide details specific to reason for referral: _____

Include applicable clinical information to assist with assessment:

☐ Current medications
☐ Diagnostic Imaging, Lab work
☐ List of medical conditions
☐ Allergies
☐ Screening i.e. PHQ9, GAD7
☐ Clinical notes

Is the patient aware of this referral? ☐ Yes ☐ No

Is the patient seeing other healthcare providers? ☐ Yes ☐ No If yes, please specify: _____

101, 217 Centre Ave, Airdrie AB, T4B 3L8 |office (587) 287-1727|fax (587) 287-1726