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| **Clinical Guideline Title** | |
| **Service Area:** | **Guideline Number:**  XX-XXX-XXX V# |
| **Approved By:** | **Approved Date:** |

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|  | **CLINICAL GUIDELINE STATEMENT** | | |
|  | **1.1** |  | |
|  |  | | |
|  | **GUIDELINE:** | | |
|  | **2.1** | **INCLUSION/EXCLUSION CRITERIA**  (Delete this section if not needed and already explained above in 1.1) | |
|  | 2.1.1 | | Important Notes |
|  | 2.1.2 | | Inclusion |
|  | 2.1.3 | | Exclusion |
|  |  | | |
|  | **2.2** | **Guideline** | |
|  | 2.2.1 | |  |
|  |  | |  |
|  | 2.2.2 | |  |
|  |  | |  |
|  | 2.2.3 | |  |
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|  | 2.2.4 | |  |
|  |  | |  |
|  | 2.2.5 | |  |
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| **3.0** | **APPLICATION:** | | |
|  | **3.1** | | **For Patients** |
|  |  | |  |
|  | **3.2** | | **For Clinicians** |
|  |  | |  |
|  | **3.3** | | **For Health Service Organizations** |
|  |  | |  |
|  |  | |  |
| 4.0 | **DEFINITIONS:** | | |
|  | **4.1** | |  |
|  | **4.2** | | **Abbreviations** |
| 5.0 | **CONTACT:**  **Provincial Project Medical Lead or PCT Lead Name,** Credentials  Department  Provincial Title, Shared Health  Email Address | | |

**Key Supporting Documents/Resources:**

**References:**

**Document Review History**

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| **Version #** | **Date** | **Reviewer** | **Action** |
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