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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 |  |
|  |  |  |
|  | 2.2.4 |  |
|  |  |  |
|  | 2.2.5 |  |
|  |  |  |
|  |  |  |
| **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,** CredentialsDepartmentProvincial Title, Shared HealthEmail Address |

**Key Supporting Documents/Resources:**

**References:**

**Document Review History**

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