

HEALTH FIRST

10 Angeline St. N., Lindsay, ON K9V 4M8

Telephone: (705) 328-6091

FAX all info to (705) 328-6202

REFERRAL FORM

Client Name _____		DOB _____ / _____ / _____ YYYY MM DD	
Home Phone Number: _____		Work Phone Number: _____	
Address: _____		City: _____	Postal Code: _____
Primary Care Provider _____		Specialist _____	
Reason for Referral: _____			
OHIP # _____		Client is appropriate for group education ☐ YES ☐ NO	
VERSION CODE			

Health History:

☐ Arthritis	☐ Diabetes	☐ Liver Disease	☐ PVD
☐ Arrhythmias	☐ Dyslipidemia	☐ Mental Health Disorder	☐ Renal Disease
☐ Blood Disorders	☐ GERD	☐ Neurological	☐ Sleep Disorder
☐ Cancer	☐ Heart Disease	☐ Obesity (BMI _____)	☐ Stroke
☐ COPD/Asthma	☐ Heart Failure	☐ Pacemaker / ICD	☐ Thyroid Disease
☐ Dementia	☐ Hypertension	Other: _____	

REFERRED TO: (Please tick all that apply)	RESULTS REQUESTED:
☐ Cardiac Rehabilitation Program (program does not provide stress tests)	Stress test (Thallium, Persantine, Echo), Lipids, ECG
☐ Pulmonary Rehabilitation Program	RESULTS OF PFT
☐ Heart Failure Physician Optimization Clinic ☐ Education only	ECHO, MUGA, ECG, CBC, Creatinine, Lytes
* ☐ Diabetes Program ☐ New Diagnosis ☐ IGT/IFG ☐ Type 1 ☐ Type 2 ☐ GDM ☐ PCOS ☐ Pregnant Present Diabetes Treatment: ☐ Lifestyle only ☐ Insulin(s): Type & Dose _____ ☐ Oral Agent(s): Type & Dose _____	A1C, FBG, OGTT, TSH, Lipids, Albumin/Creatinine Ratio, eGFR, LFT's
*Clients may be referred to the Physician Specialty Clinics unless you decline. ☐ I decline	
☒ A Certified Diabetes Educator may adjust diabetes treatment plan according to Medical Directives of the institution. For further information on the Medical Directives contact the Executive Assistant to Program Management at 705-324-6111 ext. 6218	

Physician Name: _____ Physician Signature: _____ Date: _____

OR

Allied Health Professional Referred from (eg. CCAC)

Referred By: _____

Referred From: _____

Contact Number: _____

Date: _____

OFFICE USE ONLY:	RMH unique #
Date Received:	_____
Date Triage/Initial & Priority Level:	_____
Date to be seen by:	_____
Appointment Date, Time and Clinic:	_____
Appointment Date, Time and Clinic:	_____

****PLEASE ENSURE RELEVANT FIELDS ARE COMPLETED BEFORE SENDING****