

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 _____ / _____ / _____ <small>YYYY MM DD</small>	
Home Phone Number: _____		Work Phone Number: _____	
Address: _____		City: _____	Postal Code: _____
Primary Care Provider _____		Specialist _____	
Reason for Referral: _____			
OHIP # _____		Client is appropriate for group education <input type="checkbox"/> YES <input type="checkbox"/> NO	
<small>VERSION CODE</small>			

Health History:

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

REFERRED TO: (Please tick all that apply)	RESULTS REQUESTED:
<input type="checkbox"/> Cardiac Rehabilitation Program (program does not provide stress tests)	Stress test (Thallium, Persantine, Echo), Lipids, ECG
<input type="checkbox"/> Pulmonary Rehabilitation Program	RESULTS OF PFT
<input checked="" type="checkbox"/> Diabetes Program <input type="checkbox"/> New Diagnosis <input type="checkbox"/> IGT/IFG <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> GDM <input type="checkbox"/> PCOS <input type="checkbox"/> Pregnant Present Diabetes Treatment: <input type="checkbox"/> Lifestyle only <input type="checkbox"/> Insulin(s): Type & Dose _____ <input type="checkbox"/> 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. <input type="checkbox"/> I decline	
<input checked="" type="checkbox"/> 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 Triaged/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****