ROSS MEMORIAL HOSPITAL
Kawartha Lakes

# 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 |
| *☐ **Diabetes Program**<br>☐ New Diagnosis ☐ IGT/IFG<br>☐ Type 1 ☐ Type 2 ☐ GDM ☐ PCOS ☐ Pregnant<br>Present Diabetes Treatment:<br>☐ Lifestyle only<br>☐ Insulin(s): Type & Dose _____<br>☐ 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 MRN |
|---|---|
| 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****