



HEALTH FIRST

10 Angeline St. N., Lindsay, ON K9V 4M8
Telephone: (705) 328-6091



REFERRAL FORM

FAX all info to (705) 328-6202

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: _____			
Client is appropriate for group education <input type="checkbox"/> YES <input type="checkbox"/> NO Barriers to Communicate: _____ <small>(specify)</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)	TESTS REQUIRED:
<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	PFT
<input type="checkbox"/> Supervised Diabetes Exercise Program	Stress Test, Lipids
<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
<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	
<input checked="" type="checkbox"/> Heart Failure Physician Clinic <input type="checkbox"/> Education only	ECHO, ECG, Lytes, CBC, MUGA, Creatinine
<input type="checkbox"/> Nutrition Counselling	Appropriate Lab Results

***Clients may be referred to the Physician Specialty Clinics unless you decline. I decline**

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: _____	