Rideau Community Health Services

Your Community Health Centre

Referral Form

FAX: 613-284-2591

Date of Referral: _____	**Please attach information relevant to referral:**
Client Last Name: _____	Medications: ☐ Attached
Client First Name: _____	Medical History : ☐ Attached
Gender: ☐M ☐F other: _____	Allergies: ☐ Attached
DOB (DD/MM/YYYY): _____	Client is aware of referral: ☐ Yes ☐ No
Address:	Primary Care Provider (PCP): _____
_____	Billing Number: _____
City: _____ Postal Code: _____	Referring Provider: _____
OHIP Number: _____	(if not PCP)
Client Phone: _____	Referring Provider Phone: _____
Alternate Phone: _____	Referring Provider Fax: _____

Primary Care Provider needed: ☐Y ☐ N Preferred location/community: _____

Complex Medical Needs/Health Link: ☐ Y ☐N Is Home and Community Care Involved?

☐ Mental Health ☐ Addictions ☐ Frailty ☐ Heart disease

☐ Chronic Pain ☐ Palliative ☐ Diabetes ☐ Lung disease/COPD

☐ Polypharmacy ☐ Other: _____

Dietitian:

☐ Please specify reason for referral: _____

Diabetes Education Program:

☐ Type 2 Diabetes ☐ Type 1 Diabetes ☐ Pre Diabetes

If possible, attach medication list and most recent lab results.

Foot Care:

☐ Basic Foot Care (i.e. nail care, callous care, foot care education, etc.)

☐ Advanced Foot Problem (i.e. heavy calluses, corns, fragile skin with pressure lesions, thick nails, cracked skin, reddened areas with localized foot pain, etc.)

☐ High Priority Problem (Open wound/foot ulcer or infection)

☐ Other: _____

Community Support:

☐ Form Completion Assistance ☐ Violence/Safety ☐ Funding for Medical Devices

☐ Connection to community resources ☐ Advocacy Support (i.e. ODSP, OW) ☐ Counselling

☐ Smoking Cessation Program (STOP) ☐ Other: _____

Lung Health:

☐ Spirometry Screening for COPD (Current or former smoker, >40 yrs and symptomatic)

☐ COPD (include spirometry/PFT results and any specialist notes)

☐ Asthma Education (include spirometry/PFT results and any specialist notes)

☐ Other: _____

Rehabilitation Exercise Class/Pulmonary Rehab: (all classes 8 weeks, twice weekly)

It is safe for client to participate in a light/moderate physical activity ☐Yes ☐No ** (MANDATORY RESPONSE)

☐ Chronic Disease: ☐ diagnosed with COPD or ☐ Diabetes, experiencing difficulties with ADL's. Please include confirmation of disease, recent Spirometry/PFT results and specialist notes.

☐ GLA:D Program: must be diagnosed with mild/mod hip to knee OA, experiencing difficulties with ADL's, not a surgical candidate. Please include confirmation of disease, recent X-Ray results and specialist notes.

Other: _____

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