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 ____ / ____ / ____ (YYYY / MM / DD)

Home Phone Number: _____ Work Phone Number: _____

Address: _____ City: _____ Postal Code: _____

Primary Care Provider _____ Specialist _____

Reason for Referral: _____

Client is appropriate for group education ☐ YES ☐ NO Barriers to Communicate: _____ (specify)

Health History:

☐ Arthritis	☐ Diabetes	☐ Liver Disease	☐ PVD
☐ Arrythmias	☐ 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)	**TESTS REQUIRED:**
☐ **Cardiac Rehabilitation Program** (program does not provide stress tests)	Stress test (Thallium, Persantine, Echo), Lipids, ECG
☐ **Pulmonary Rehabilitation Program**	PFT
☐ **Supervised Diabetes Exercise Program**	Stress Test, Lipids
*☐ **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
☒ **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**	
*☐ **Heart Failure Physician Clinic** ☐ Education only	ECHO, ECG, Lytes, CBC, MUGA, Creatinine
☐ **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 Triaged/Initial & Priority Level: _____

Date to be seen by: _____

Appointment Date, Time and Clinic: _____

Appointment Date, Time and Clinic: _____