INTEGRATED CHRONIC CARE SERVICE (ICCS)

REFERRAL FORM

DATE REFERRED _____
YYYY/MM/DD

PATIENT INFORMATION			
Health Card Number (HCN):			
Last Name:			
First Name:			
Date of Birth:	MONTH	DAY	YEAR
Gender:			
Address	Street:		
	City:		
	Province:		
	Postal Code:		
Home Phone Number			
Work Phone Number			
Cell Number:			
Occupation:			
Is this a WCB Claim?	☐ Yes	☐ No	☐ Unknown
	If Yes, Claim Number:		

PARENT, GUARDIAN OR FAMILY MEMBER	
Name:	
Phone Number:	

REFERRING PHYSICIAN – FAMILY DOCTOR	
Name:	
Direct Phone Number:	
Fax Number:	

BRIEF HISTORY

CO-MORBID CONDITIONS (List all that apply)

PRESENTING SYMPTOMS	
PREVIOUS / ONGOING TREATMENT (of relevance to current problem)	
1.	5.
2.	6.
3.	7.
4.	8.
CURRENT MEDICATIONS	
1.	5.
2.	6.
3.	7.
4.	8.
PLEASE ATTACH A SEPARATE MEDICATION SHEET IF YOU REQUIRE ADDITIONAL SPACE	
ALLERGIES	
REASON FOR REFERRAL	
WHAT IS (ARE) THE PRESENT CHALLENGE(S) IN MANAGING CARE FOR THE PATIENT?	
THIS HELPS OUR TEAM UNDERSTAND THE TYPE OF SUPPORT YOU ARE SEEKING IN MANAGING THE PATIENT	
RELEVANT REPORTS	
PLEASE ATTACH RELEVANT CONSULTANT REPORTS AND INVESTIGATIONS SUCH AS REPORTS ON IMAGING, BLOODWORK OR EMGs	
ICCS REFERRAL OPTIONS (please check the option you are seeking with this referral)	
☐ Integrated assessment ☐ Whole-person education ☐ Both	
OTHER COMMENTS OR NOTES OF IMPORTANCE	
SIGNATURE	
In referring this patient, I agree to provide appropriate follow-up care once the patient is discharged from ICCS care	
Signature:	**Date:** (YYYY/MM/DD)

PLEASE FAX REFERRAL FORM TO: (902) 860-2046

Contact for Clinical Coordinator, Rob Dickson

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