

Date of Referral (dd/mm/yy):	PLEASE ATTACH INFORMATION RELEVANT TO REFERRAL:	
Client Last Name:	Medications:	<input type="checkbox"/> Attached
Client First Name:	Medical History:	<input type="checkbox"/> Attached
Date of Birth (dd/mm/yy):	Allergies:	<input type="checkbox"/> Attached
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other:	Client is aware of referral: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address:	Primary Care Provider (PCP):	
City:	Billing Number:	
Postal Code:	Referring Provider (if not PCP):	
OHIP Number:	Referring Provider Phone:	
Client Phone:	Referring Provider Fax:	
Alternate Phone:		
<input type="checkbox"/> Complex Medical Needs: Is Home and Community Care Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Mental Health <input type="checkbox"/> Addictions <input type="checkbox"/> Frailty <input type="checkbox"/> Lung Disease / COPD <input type="checkbox"/> Heart Disease <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Palliative <input type="checkbox"/> Diabetes <input type="checkbox"/> Polypharmacy <input type="checkbox"/> Other: Please provide further details:		
<input type="checkbox"/> Dietitian: Please specify reason for referral and attach relevant lab results and medication list:		
<input type="checkbox"/> Diabetes Education Program: Attach medication list and recent lab results. <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Pre-Diabetes Please provide further details:		
<input type="checkbox"/> Foot Care: Please specify below. Include medication list or Cumulative Patient Profile (CPP) for Advanced/High Risk. <input type="checkbox"/> <u>Foot Care Education Class:</u> For individuals requiring education on proper foot care. Caregivers or healthcare professionals welcome. Diabetes Foot Exam offered to all participants with diabetes. <input type="checkbox"/> <u>Advanced Foot Care Nurse:</u> reserved for individuals with annual income of \$39,000 or less and diagnosed with diabetes or other health condition that increases ulcer/amputation risk. Heavy callouses, corns, fragile skin with pressure lesions, thickened/fungal nails, cracked skin, skin anomalies, ingrown toenails. <input type="checkbox"/> <u>High Risk Chiropody:</u> open foot wounds or ulcers, slow healing wounds, off loading devices, footwear modification. Note: If patient has an infected wound, ensure prescriptions are initiated and refer to Home and Community Care Support Services for wound care.		
<input type="checkbox"/> Community and Social Supports: <input type="checkbox"/> Form Completion Assistance <input type="checkbox"/> Food Security <input type="checkbox"/> Smoking Cessation <input type="checkbox"/> Income Support (i.e. ODSP, OW) <input type="checkbox"/> Counselling/Social Work <input type="checkbox"/> Connection to Community Resources <input type="checkbox"/> Other:		
<input type="checkbox"/> Virtual Health Care/ Telemedicine Support: Client requires nurse support to connect to healthcare appointments virtually (i.e. homebound, transportation barriers). Please provide further details:		
<input type="checkbox"/> Trans Health Program: <input type="checkbox"/> Client is masculinizing (assigned Female at Birth) <input type="checkbox"/> Client is Feminizing (assigned Male at Birth) Please provide further details:		
Additional Comments:		