**Referral Form** Ver:June 2020

**45-360 George Street North,
Peterborough, ON K9H 7E7**

**Phone: 705-874-3900 Fax: 705-874-5339**

**To help us prioritize our referrals please advise us if you:**

[ ]  do not have a family doctor or nurse practitioner close enough that you can access them

[ ]  do not have a fixed address (homeless) [ ]  are a Home for Good participant

[ ]  are a refugee

[ ]  identify as Indigenous, First Nations, Métis, Inuit
[ ]  are a transgender person seeking supportive health care

[ ]  are not eligible for coverage from ON Health Insurance (OHIP)/Interim Federal Health Program (IFHP)

**Today’s Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Last Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**: (DD/MM/YR) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Language:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gender:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Pronouns:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Card Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_VC (2 letters) \_\_\_\_\_\_\_\_\_\_ [ ] No Health Card

**Are you registered with Health Care Connect?** [ ]  Yes [ ]  No

**Phone #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We request your email address to email you about appointments, send you health information, and to invite you to a video visit. All emails sent to you will be a permanent part of your medical record. We will not divulge your email address to anyone.

The 360 NP-Led Clinic will take reasonable means to protect the security of all patient emails. You understand that email sent to you can be read by other people if you leave your email open on shared or public computers. You agree to protect your email correspondence and will not hold the Peterborough 360 Degree Clinic or their staff responsible if confidential information is made public through your actions. You agree that you will not hold the 360 NP-Led Clinic liable for information lost due to technical failures beyond the control of the Clinic.

**Please sign here to allow us to email you:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is the best way to reach you?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you provide us a phone number, **can we leave a message for you?** [ ]  Yes [ ]  No



**Referral Form Page 2 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is there someone we can talk to about the time & date of your next medical appointment?**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (a person’s name or “any worker”)

Organization \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**We may meet with you in person, by phone or by video. Please tick what you have access to:**

[ ]  A device with a camera and microphone (e.g. smart phone, tablet, computer) [ ]  Strong Internet

[ ]  A phone with minutes [ ]  A (private) space in which you are comfortable discussing your health

**Dependents you would like to register (please use reverse if more space is needed):**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Where have you been receiving health care over the past 2 years?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address and phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you involved with other community agencies such as CMHA, Fourcast, etc.?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Briefly list any of your health concerns and medications you are currently on:**

|  |  |  |
| --- | --- | --- |
| **FOR ADMIN USE ONLY** | **Date** | **Initial** |
| Received |  |  |
| If HAPP – call & add/update waitlist |  |  |
| Priority: YES [ ] No [ ] |  |  |
| Criteria: |
| Updated/Added to waitlist: |  |  |
| Appointment Booked: |  |  |