ROSS MEMORIAL HOSPITAL
Kawartha Lakes

HEALTH FIRST

10 Angeline St. N., Lindsay, ON K9V 4M8
Telephone: (705) 328-6091
FAX all info to (705) 328-6202

REFERRAL FORM

Client Name _____ DOB _____ / _____ / _____
YYYY MM DD

Home Phone Number: _____ Work Phone Number: _____

Address: _____ City: _____ Postal Code: _____

Primary Care Provider _____ Specialist _____

Reason for Referral: _____

OHIP #_____ _____ VERSION CODE

Client is appropriate for group education ☐ YES ☐ NO

Health History:

☐ Arthritis	☐ Diabetes	☐ Liver Disease	☐ PVD
☐ Arrhythmias	☐ 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)	**RESULTS REQUESTED:**
☐ **Cardiac Rehabilitation Program** (program does not provide stress tests)	Stress test (Thallium, Persantine, Echo), Lipids, ECG
☐ **Pulmonary Rehabilitation Program**	RESULTS OF PFT
☐ **Heart Failure Physician Optimization Clinic** ☐ Education only	ECHO, MUGA, ECG, CBC, Creatinine, Lytes
*☐ **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

***Clients may be referred to the Physician Specialty Clinics unless you decline.** ☐ **I decline**

☒ **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**

Physician Name: _____ Physician Signature: _____ Date: _____

OR

Allied Health Professional Referred from (eg. CCAC)

Referred By: _____
Referred From: _____
Contact Number: _____
_____
Date: _____

OFFICE USE ONLY:	RMH MRN
Date Received:	
Date Triaged/Initial & Priority Level:	
Date to be seen by:	
Appointment Date, Time and Clinic:	
Appointment Date, Time and Clinic:	

****PLEASE ENSURE RELEVANT FIELDS ARE COMPLETED BEFORE SENDING****