Central Brampton Family Health Team

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Program Referral Form

SECTION A (Demographic Information— affix label)

Referring Provider:

Name: _____

Phone: _____ Fax: _____

Address: _____

SECTION B (to be completed by referring PCP)

Please attach patient's **MOST RECENT LAB/DI REPORTS, ANY RELEVANT CLINICAL NOTES,** and **LIST OF CURRENT MEDICATIONS AND ALLERGIES** that would be relevant to the program or service selected in this referral.
Programs in phase 1 will have additional services added in the future.

Please select the program(s) or service:

- ☐ **Mental Health Services**
  - ➢ Mild to moderate mental health concerns
- ☐ **Lung Health Program** – *select from the following services and attach recent spirometry test results*
  - ☐ Spirometry Testing
  - ☐ Asthma & COPD Education (Pathophysiology; Puffer Education; Action Plan)
  - ☐ Review of Resp. Medication
  - ☐ Smoking Cessation (Free NRT)
- ☐ **Diabetes Management Program** *(Phase 1)*
  - ➢ Diabetes education (CDE)
  - ➢ Medication review and support
  - ➢ Hypertension/hyperlipidemia education
  - ➢ Nutrition counselling
  - ➢ Care coordination
- ☐ **Seniors Wellness Program** *(Phase 1) – select from the following services:*
  - ☐ Weight and/or nutrition concerns
  - ☐ Polypharmacy
  - ☐ Frequent falls/mobility concerns
  - ☐ Functional decline (ADL & IADL concerns)
  - ☐ Psychosocial concerns
  - ☐ Advanced care planning
  - ☐ Care coordination/patient navigation
- ☐ **Nutrition Services – Dietitian**
- ☐ **Health and Lifestyle Educator**
- ☐ **Highway to Health (formerly known as CHANGE Program)**

Any additional relevant information: _____

_____

Date: _____ **Signature of Referring Provider:** _____