Sunset Country Family Health Team

1-35 Wolsley Street
Kenora, ON P9N 0H8
Phone: (807) 468-6321
Fax: (807) 468-3978
www.scfht.ca

PATIENT INFORMATION

First Name: _____ **Preferred Name:** _____
Last Name: _____ **Preferred Gender:** _____
Address: _____
Phone: _____ **Cell:** _____
Date of Birth: _____ **HC#:** _____

***Alternate Contact Information** (if patient is unable to make own appointment, ie. young child, etc.)*

First Name: _____ **Phone:** _____

Referral to the following program(s):

Send TO DO to FHT Central Intake

- ☐ Cervical Cancer Screening (PAP)
- ☐ Chiropody Services
- ☐ Chronic Disease Self-Management
- ☐ Hypertension Management
- ☐ INR
- ☐ Lactation Services
- ☐ Lung Health – Asthma/COPD (Spirometry) *(Please fax ER Record to SCFHT)*
- ☐ Medication Review / Counselling
- ☐ Memory Clinic *(Please use specific section below)*
- ☐ Occupational Therapy
- ☐ Registered Dietitian
  - ☐ *Prediabetes* ☐ *Dyslipidemia* ☐ *OTHER:* _____
- ☐ Smoking Cessation
- ☐ Social Work
  - ☐ *System Navigation* ☐ *Short Term Counselling*

■ For referring to the Diabetes Program, please use the DMP referral form

THIS SECTION MUST BE COMPLETED FOR ALL REFERRALS EXCLUDING DMP AND MEMORY CLINIC

☐ Urgent Referral – To be booked:

☐ 1-2 weeks ☐ 3-4 weeks ☐ Next available

For Hypertension referral:

Patients last BP:_____/_____

Reason for referral / additional information:

For Chiropody Referrals:

- ☐ High Risk Diabetic Foot Care
- ☐ Biomechanical Foot Assessment
- ☐ Custom Foot Orthotics
- ☐ Corns, Hyperkeratosis
- ☐ Diabetic Foot Care (provided by Foot Care RPN)
- ☐ Other: _____

Wounds – Please refer to the Wound Assessment Clinic at LWDH, fax to (807) 468-7096

MEMORY CLINIC REFERRALS

Reason for referral: _____

Is this referral URGENT? ☐ Yes ☐ No

PLEASE ENSURE the following are included with the referral (if bloodwork has not been completed please attempt to have it completed prior to memory clinic assessment):

- ☐ **Consult report / Specialist report**
- ☐ **EKG**
- ☐ **CT Scan / MRI**
- ☐ **Current medication list**
- ☐ **Significant medical history**
- ☐ **Patient has been informed that driving concerns will be assessed at this assessment**
- ☐ **CBC**
- ☐ **TSH**
- ☐ **Creatinine**
- ☐ **Electrolytes**
- ☐ **Glucose**
- ☐ **Vitamin B12**
- ☐ **Calcium**

****A caregiver/family member is required to attend the appointment with the patient ****

Caregiver/Family Member Information:

Name: _____
Phone: _____
Relationship to patient: _____

Permission from patient to contact caregiver/family member:

☐ **Yes** ☐ **No**

Please fax to the Sunset Country Family Health Team at (807) 468-3978

Referred by: Signature: