Sunset Country Family Health Team

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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:** _____

Section 1: Appointment timeline

☐ Next Available ☐ 1-2 weeks ☐ 3-4 weeks ☐ Urgent referral required by: _____.

Section 2: Program referral

To refer to the following programs the patient must be rostered/registered with one of the following clinics; SCFHT NP Clinic, DocSide, Keewatin Medical Clinic or Kenora Medical Associates (KMA)

☐ Cervical Cancer Screening (PAP)
☐ Chronic Disease Self-Management
☐ Medication Review/Counselling
☐ Smoking Cessation
☐ Registered Dietitian
☐ Prediabetes ☐ Dyslipidemia
☐ Other:_____.
☐ Chiropody Services
☐ Hypertension Management (pts last BP_____/_____)
☐ Lung Health: diagnosed with Asthma/COPD
☐ Social Work
☐ System Navigation ☐ Short Term Counselling
☐ Other:_____.

The following programs are open to referral for patients with a primary care provider from an organization other than the above noted clinics.

☐ INR ☐ Occupation Therapist ☐ Memory Clinic - section 4 must be completed

The following programs are open to referral for patients without a primary care provider

☐ Lung Health - Spirometry
☐ Lactation Services
☐ Diabetes Programs – *please use the DMP referral Form*
☐ Primary Care Outreach

Section 3: Reason for referral/ additional notes

Section 4: 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 the memory clinic assessment)
☐ Consult Report/Specialist report
☐ Current Medication List
☐ Significant Medical History
☐ CBS ☐ EKG ☐ TSH ☐ CT Scan/MRI ☐ Creatinine
☐ Electrolytes ☐ Glucose ☐ Vitamin B12 ☐ Calcium
☐ Patient has been informed that driving concerns will be assessed at this assessment

****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**

Referred By: **Signature**: **Date**:

FAX TO: 807-468-3978 or Send an EMR message to FHT Central Intake