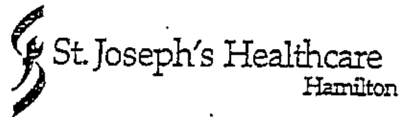

Centre for Ambulatory Health Services
2757 King Street East
Hamilton, Ontario, Canada L8G 5E4
Tel. (905) 573-7777

REFERRAL FORM

PATIENT/CLIENT/IDENTIFICATION

Last Name ______ First Name ______ D.O.B. ___/___/___ (yr/mo/day) ☐ Male ☐ Female

Address ______ City ______ Province ______ Postal Code ______

HomeTelephone ______ Business Telephone ______ Health Care # ______

Current living arrangements: ☐ Alone ☐ Spouse ☐ Family ☐ Institution ☐ Other ______

CARE PROVIDER IDENTIFICATION/CONTACT PERSON

Last Name ______ First Name ______

Address ______ City ______ Province ______ Postal Code ______

HomeTelephone ______ Business Telephone ______ Relationship ______

REFERRAL SOURCE

Last Name ______ First Name ______

Address ______ City ______ Province ______ Postal Code ______

Discipine ______ Name of Service ______ Office Telephone # ______

☐ Family Physician ☐ Consulting Physician ☐ Other

CURRENT MEDICAL DIAGNOSES & RELEVANT PAST DIAGNOSES:

REASON FOR REFERRAL:

ALLERGIES AND MEDICATION:

☐ No known allergies
☐ Drug allergies ______
☐ Food allergies ______

Prescribed Medications: ______

PD 3982 6/01 *Please turn over and check off the appropriate information under the program to which you are referring.

☐ ASTHMA EDUCATION PROGRAM Phone: 905.573.7777 Ext. 8403 Fax: 905.573.4815

Indicate education level you suggest:

☐ level 1: General asthma and drug information, drug information, drug delivery techniques, and spirometry (pre & post bronchodilator: 2 puffs, ventolin 100 mcg or client's usual bronchodilator)

☐ level 2: Includes level 1 information, follow-up visits, peak flow monitoring, spirometry (pre & post bronchodilator: 2 puffs, ventolin 100 mcg or client's usual bronchodilator) and implementation of action plan as instructed by referring physician.

☐ CHIROPODY Phone: 905.573.4817 Fax: 905.573.4815

Consultation note requested: ☐ Yes ☐ No

Permission given for Chiropodist to order:

☐ Culture and sensitivity test for ulcers

☐ X-rays of the feet to assess osteopathic changes

☐ CONTINENCE PROGRAM Phone: 905.573.4823 Fax: 905.560.1574

COMMUNICATION DISORDERS Phone: 905.573.4803 Fax: 905.573.4838

☐ Audiology WCB Claim # ______________________ (if applicable)

☐ Speech-Language Pathology

* Unless otherwise indicated, all patients referred for SLP assessment will have an Audiometric Screening.

☐ DIABETES PROGRAM NEW REFERRAL Phone: 905.573.4819 Fax: 905.573.4843

☐ RE- REFERRAL

Please send Lab results (Fasting Glucose/HbA1C) with referral

Your referral and signature at the bottom of this form authorizes:

- dietitian to alter meal plans
- RN to arrange blood and urine tests as indicated.
- Prescribed medication (i.e. Insulin/oral hypoglycemics) will be adjusted according to blood glucose patients and in accordance with the policies and procedures of St. Joseph's Healthcare, Hamilton, Centre for Ambulatory Health Services.

Duration and Type of Diabetes: ________ years ☐ IDDM ☐ NIDDM Insulin (type & dose) ______________

Diet Restrictions ______________________ Oral Agents (type & dose) ______________

☐ HEALTH FOR OLDER ADULTS PROGRAM (GERIATRICS) Phone: 905.573.4818 Fax: 905.573.4820

☐ STAY WELL PROGRAM Phone: 905.573.4844 Fax: 905.573.4820

☐ COMMUNITY NUTRITION PROGRAM Phone: 905.573.4805 Fax: 905.573.48343

☐ High BP ☐ Smokes ☐ Sedentary ☐ CVD

☐ Weight management (group education program) ☐ Eating disorder referral

☐ Individual Nutrition Counseling ☐ Psychoeducational Group ☐ Both

---

SIGNATURE OF REFERRING PROFESSIONAL

______________________ ______________

Signature Date

☐ ASTHMA EDUCATION PROGRAM Phone: 905.573.7777 Ext. 8403 Fax: 905.573.4815

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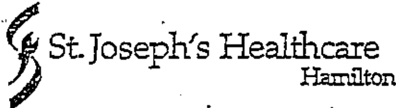
SIGNATURE OF REFERRING PROFESSIONAL

______________________ ______________

Signature Date



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