

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

REFERRAL FORM

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PATENT/CLIENT/IDENTIFICATION				
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Last lame	First Name		O.O.B. (yr/mo/	' ☐ Male ☐ Femi 'dav)
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Addres	City	Province	ce	Postal Code
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Hom€Telephone	Business Tele	phone	Health Ca	re#
Current living arrangements: 🗌 Alor	e 🗌 Spouse 🔲 F	amily 🔲 Institution	Other_	·
CAFE PROVIDER IDENTIFICATION	V/CONTACT PERSON	<u> </u>	 	-
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25t falls /	First N	ame		-
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lomeTelephone	Business Telep	phone	Palatianah	•
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REFERRAL SOURCE				
ast Name	First Na	ime	· ,	
				•
ddress	City	Province	•	Postal Code
iscipine	Name of Service			
Family Physician 🔲 Consulting			Office Telep	hone #
URRENT MEDICAL DIAGNOSES	& RELEVANT PAST I	DIAGNOSES:	•	
EASON FOR REFERRAL:				
				•
LLERGIES AND MEDICATION:				•
No known allergies				
Drug allergies				
Food allergies		MT-1	···	
				
escribed Medications:			<u> </u>	
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ASTHMA EDUCATION PROGRAM	RAM Phone: 905.573.7777 Ext. 8403 Fax: 905.573.4815				
In deate education level you suggest: level 1: General asthma and drug informations bronchodilator: 2 puffs, ventolin 100 meg of					
Level 2: Includes level 1 information, follow 2 puffs, ventolin 100 mcg or client's usual bron physician.					
CHIROPODY	Phone: 905.573.4817	Fax: 905.573.4815			
Consultation note requested: Yes No Pernission given for Chiropodist to order: Culture and sensitivity test for ulcers X-rays of the feet to assess osteopathic cha	anges				
CONTINENCE PROGRAM:	Phone: 905.573.4823	Fax: 905.560.1574			
COMMUNICATION DISORDERS	Phone: 905.573.4803	Fax: 905.573.4838			
Audiology WCB Claim #	SLP assessment will have an A	(if applicable)			
DIABETES PROGRAM NEW REFERRAL RE- REFERRAL		Fax: 905.573.4843 ***Please send Lab results			
	s indicated. hypoglycemics) will be ad	(Fasting Glucose/HbA1C) with referral** justed according to blood glucose patients			
and in accordance with the policies an Ambulatory Health Services. Duration and Type of Diabetes:yea	ars IDDM NIDDM	Insulin (type & dose)			
Diet Restrictions	Oral A	Agents (type & dose)			
☐ HEALTH FOR OLDER ADULTS PROGRAI	M (GERIATRICS) Phone	e: 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 ☐ Sedenta☐ Weight management (group education prog☐ Individual Nutrition Counseling ☐ Psy	ram) 🔲 Eating disorde	er referral			
SIGNATURE OF REFERRING PROFESSIONA	AL.	•			
Signature	Dat				

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ASTHMA EDUCATION PROGRAM	** ASTHMA EDUCATION PROGRAM Phone: 905.573.7777 Ext. 8403 Fax: 905.573.4815						
In deate education level you suggest:		•					
	ion, drug information, drug	delivery techniques, and spirometry (pre &					
level 1: General asthma and drug information, drug information, drug delivery techniques, and spirometry (pre & pos bronchodilator: 2 puffs, ventolin 100 mcg or client's usual bronchodilator)							
Level 2: Includes level 1 information, follow	-up visits, peak flow monite	pring, spirometry (pre & post bronchodilator:					
2 puffs, ventolin 100 mcg or client's usual brond	- · · ·	- ·					
physician.							
CHIROPODY	Phone: 905.573.4817	Fax: 905.573.4815					
Consultation note requested: Yes No							
Pernission given for Chiropodist to order:	,						
Culture and sensitivity test for ulcers							
☐ X-rays of the feet to assess osteopathic cha	ndes .						
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 SI	LP assessment will have an Au	diometric Screening.					
DI DIABETES PROGRAM NEW REFERRAL	Phone: 905.573.4819	Fax: 905.573.4843					
☐ RE- REFERRAL		, and the same of					
		**Please send Lab results					
Your referral and signature at the bottom of this	form authorizes:	(Fasting Glucose/HbA1C) with referral**					
 dietitian to alter meal plans 		Traditional .					
 RN to arrange blood and urine tests as 	indicated.						
 Prescribed medication (i.e. Insulin/oral) 	nypoglycemics) will be adju	usted 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:yea	rs 🗌 IDDM 🔲 NIDDM	Insulin (type & dose)					
Diet Restrictions	Oral A	gents (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 ☐ Sedentar	y 🔲 CVD						
☐ Weight management (group education progra	-	referral					
		☐ Both					
SIGNATURE OF REFERRING PROFESSIONAL							
•		•					
Signature	Date						

St. Joseph's Healthcare

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

REFERRAL FORM

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HomeTelephone	Busin	ess Telephone		Health Car	re #	
Current living arrangements: Alc		• *	☐ Institution (Other_		·
CAFE PROVIDER IDENTIFICATION	N/CONTACT PE	ERSON	· · · · · · · · · · · · · · · · · · ·			
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Last fame .		First Name				
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REFERRAL SOURCE					-	
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Last Name		First Name			 -	
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Address	City		Province		Postal Code	
Discipine	Name	of Service		Office Telep	phone #	
☐ Family Physician ☐ Consultin		1 Other			,	
CURRENT MEDICAL DIAGNOSES & RELEVANT PAST DIAGNOSES:						
		•		•	•	
REASON FOR REFERRAL:	•					
ALLERGIES AND MEDICATION:						
☐ No known allergies		•				
☐ Drug allergies						
☐ Food allergies						
Prescribed Medications:						
						
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