CACE | Centre for Ambulatory Care Education
COMPLEX CARE CLINIC

REFERRAL FORM

Date: _____/___/___
YYYY/MM/DD

Name:
DOB:
HC#:
Telephone:
Address:
MRN/Visit # (UHN only)

Referral Physician Expectations:
☐ One time consultation
☐ Consider ongoing co-management for this issue(s)
☐ Urgent appointment requested
☐ Next available appointment **OR**
☐ Specific MD_____
☐ Other: _____

Referral From:
☐ Family Medicine
☐ Emergency
☐ Post-discharge
☐ Community Care Access Centre (CCAC)
☐ Ambulatory Internal Medicine Group Practice Sub-specialty
☐ Virtual Ward/Clinical Decision Unit
☐ Other: _____

Hospital/Site:
☐ WCH ☐ TGH
☐ TWH ☐ Other:_____
UHN Visit #: _____

Referring Physician: _____

Referring Physician OHIP Billing Number: _____

Referring Physician Telephone Number: _____

Referring Physician Fax Number: _____

Family Physician (if different than referring): _____

Family Physician Fax Number: _____

Interpreter needed ☐ Yes ☐ No

☐ **Language:** _____

Main reason for referral/most important issue(s) for the patient:: _____

_____

_____

_____

_____

What other service/specialties has this patient seen for this issue(s) (if any)? ☐ **Not applicable**

_____

_____

_____

_____

Co-morbidities:_____

_____

Attach all relevant documentation available including imaging, labs, discharge summaries, consultation letters, and pathology. Identify any critical results below: _____

Attachments ☐ Yes ☐ No

Specify if you recommend that your patient also needs to be assessed by a member of our inter-professional team:

☐ Respiratory Therapist ☐ Nurse ☐ Occupational Therapist ☐ Pharmacist ☐ Physiotherapist
☐ Social Worker ☐ Dietitian ☐ CCAC ☐ Mental Health

Rationale: _____

Print Name: _____ Signature _____Designation _____

PLEASE FAX COMPLETED REFERRAL TO 416-323-7739

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www.womenscollegehospital.ca

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