Telemedicine IMPACT Plus (TIP)
Interprofessional Clinic for Patients with Complex Care Needs

What is TIP?

TIP (Telemedicine IMPACT Plus) provides rapid access to a virtual team of professionals to enable proactive health and social care for patients with complex conditions, and their family caregivers.

Telemedicine IMPACT Plus is an OHIP-Billable Service that supports coordinated care planning and derives new solutions for addressing the patient’s chronic conditions.

The Primary Care Provider, patient, and their family caregivers benefit from the support of a dedicated nurse who coordinates the patient’s circle of care. The TIP consultation clinic empowers the patient and their caregivers to manage complex health conditions.

TIP consulting teams have a core membership (as required) of a:
- Psychiatrist
- Internist
- Pharmacist
- Dietician
- Social Worker
- Home and Community Care Coordinator

Some of our teams offer specialty consults in:
- Geriatric Medicine
- Geriatric Psychiatry
- Diabetes
- Endocrinology
- Pain Management
- Intellectual and Developmental Disabilities

Which patients do I refer?

- Patients with multiple chronic conditions and medications.
- Frequently hospitalized patients in need of access to psychiatric, mental health or social supports.
- Patients who could benefit from coordinated care planning.

Why should I refer to TIP?

- Access psychiatric and internist consultation within weeks or sooner.
- Develop a Coordinated Care Plan.
- Navigate health and community resources with a dedicated nurse.
- Build and foster resiliency by enhancing access to local resources.
- Gain supports to help manage the patients who “keep you up at night”.

For more information, please contact:

Mid-West Toronto Sub-Region Team
Phone: 416-603-5800 x4015
Email: TIPteam@uhn.ca

To refer a patient, please complete the attached referral form

March 2019
Telemedicine IMPACT Plus (TIP) Referral Form
Interprofessional Clinic for Patients with Complex Care Needs

Referral Source:
Date of Referral (mm/dd/yy):
Referral Source Name:
Phone No:

Primary Care Provider Name:
Street Address:
Postal Code: Phone No: Fax No:
OHIP Billing No:
Email:

Patient Demographics:
Patient Last Name: Patient First Name:
OHIP No: VC: DOB (mm/dd/yy):
Gender:
Address:
Postal Code: Major Intersection:
Can we leave messages at this number? Yes ☐ No ☐
If applicable, name of Substitute Decision Maker (SDM):
SDM Relationship: Telephone No:

Referral Checklist:
1. Yes ☐ No ☐ Unknown ☐ Patient consents to participate in TIP
2. Yes ☐ No ☐ Unknown ☐ Interpreter Required. Language:
3. Yes ☐ No ☐ Unknown ☐ Five or more medications prescribed
4. Yes ☐ No ☐ Unknown ☐ Two or more chronic conditions present
5. Yes ☐ No ☐ Unknown ☐ Care is difficult to manage due to complications of co-existing conditions
6. Yes ☐ No ☐ Unknown ☐ Cognitive impairment concerns
7. Yes ☐ No ☐ Unknown ☐ Mental health or substance use issues
8. Yes ☐ No ☐ Unknown ☐ Frequent hospital/emergency department visits
9. Yes ☐ No ☐ Unknown ☐ Patient has been diagnosed with diabetes
10. Yes ☐ No ☐ Unknown ☐ Patient receives services from Home and Community Care
11. Yes ☐ No ☐ Unknown ☐ Patient receives end of life care

Are you aware of any precautions staff should take when visiting the patient’s home? Yes ☐ No ☐ Unknown ☐
if yes, please describe:

Priority issues—List concerns you would like addressed during this 1-hour consult:

Please fax completed form to 1(888)401-6675
March 2019