Markham Family Medicine Teaching Unit
Health for All
FAMILY HEALTH TEAM

Health for All
Community Care Team

379 Church Street, Unit #214
Markham, ON L6B 0T1
Tel: 905-472-2200 ext. 290 Fax: 905-472-5662
communitycareteam@healthforallfht.ca
www.healthforallfht.ca/our-programs/cct/

Interprofessional Primary Care Referral Form

Patient Information:

First and Last Name

Address

Date of Birth (DD/MM/YY)

Gender Identity

Home Number

Mobile Number

Health Card Number

Email

Preferred Language

To be eligible for CCT services, the patient must live or have a health care provider in the Eastern York Region

North Border: Davis Drive

South Border: Steeles Ave

West Border: 404/ Langstaff/Yonge St

East Border: York-Durham Townline

Are you from a community based organization? Yes ☐ **No** ☐

Organization Name (if applicable)

Provider Information (If applicable):

Name

Phone Number

Fax Number

STAMP AREA

Has the Patient been informed of this referral? Yes ☐ No ☐ Signature _____

*** Please note: HFAFHT CCT is not an emergency service**. If the patient requires immediate support, please advise them to go to the nearest emergency room, call 9-1-1 or call Telehealth Ontario 1-866-797-0000.

Include with Referral any relevant clinical reports (previous consult notes and clinical evaluation)

Service Required- check all that is applicable:

☐ Nurse Practitioner — Reason for Referral (Please check all that apply):	Other Relevant Information
☐ Primary care for unattached individuals or those without OHIP ☐ Cancer Screening ☐ Chronic disease management ☐ Home visiting program ☐ PrEP (preexposure prophylaxis) ☐ Other: _____	

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☐ Case Manager — Reason for Referral (Please check all that apply):	Other Relevant Information
☐ Connecting to community ☐ Connecting to government services ☐ Assistance with application for services ☐ Advocacy for services or supports ☐ Coordinating with home and community care ☐ Other:_____	Diagnosis: _____ Current social assistance or social supports in place: ☐ OW ☐ ODSP ☐ LHIN/CCAC/CHATS ☐ CMHA ☐ YSSN ☐ Veterans Affairs Additional notes:

☐ Social Worker — Reason for Referral (Please check all that apply):	Other Relevant Information
☐ Adjustment ☐ Separation ☐ Stress ☐ Anxiety ☐ Gender identity ☐ Addictions and substance abuse ☐ Grief/loss issues ☐ Other: _____	

☐ Pharmacist — Reason for Referral (Please check all that apply):	Other Relevant Information
☐ Smoking Cessation (STOP Program) ☐ Medication Reviews and Assessment ☐ Drug Information ☐ Drug/Herbal Interactions ☐ De-prescribing ☐ Chronic Disease Management (e.g. hypertension, dyslipidemia, chronic pain, insomnia, etc.) ☐ Diabetes (medication management, insulin start and/or titration, education) ☐ Other: _____	

☐ Dietitian — Reason for Referral (Please check all that apply):	Other Relevant Information
☐ Heart Health (dyslipidemia, hypertension) ☐ Gut Health (IBS, IBD, diverticular disease) ☐ Diabetes (Type 2, prediabetes) ☐ Disordered Eating Habits ☐ Food allergies and intolerances ☐ Prenatal or postnatal nutrition ☐ Other: _____	Diagnosis: _____ Medical History: Additional notes:

Thank you for your referral to our community based care team. You may fax the referral to us. Once the referral has been received you will receive a confirmation fax from us and any consult notes pertaining to your patient's care will be sent to you after the initial consultation where applicable.

If you have any questions about this program at anytime, please do not hesitate to contact us.