379 Church Street, Unit #214
Markham, ON L6B 0T1
289-859-1300
905-472-5662
healthforallfht.ca/community-care-team/

Interprofessional Primary Care Referral Form

***NEW* E-referrals can now be done via Ocean**

Eligibility Criteria: Patient must reside in Markham or Stouffville

Please note: We do not provide time-sensitive or urgent services.

Patient Information:

First Name			Last Name		
Address					
Date of Birth	(DD/MM/YY)	Gender Identity		Sex at Birth	
Home Number			Mobile Number		
Health Card Number			Preferred Language		
E-mail					

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

STAMP AREA

Provider/Referrer Information:

Name & Position	
Phone Number	
Fax Number	

Signature: _____

Service(s) Required: *(Check all that apply)*

☐ **Nurse Practitioner Reason for Referral:** *(Please check all that apply)*

☐ Primary care services (all ages/family) for unattached patients: comprehensive healthcare services including regular checkups, treatment of common illnesses, ongoing management of long-term conditions, and preventive care.

Please note: Patients must have OHIP to access primary care services

☐ Woman's Health Clinic - cervical cancer screening, IUD removal/insertion, pessary care.

Other Relevant Information:

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☐ **Social Worker/Psychotherapist***

Reason for Referral: *(Please check all that apply)*

- ☐ Adjustment
- ☐ Separation
- ☐ Stress
- ☐ Anxiety
- ☐ Gender identity
- ☐ Addictions and substance abuse
- ☐ Grief/loss issues
- ☐ Other: _____

Does patient have private insurance?

Due to the high volume of referrals currently being received, we are unable to accept patients with private insurance coverage at this time.

***Note: Clients must be aged 17 or older for Social Work services.**

Other Relevant Information:

☐ **Pharmacist**

Reason for Referral: *(Please check all that apply)*

- ☐ 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: _____

Other Relevant Information:

☐ **Dietitian**

Reason for Referral: *(Please check all that apply)*

- ☐ Heart Health (dyslipidemia, hypertension)
- ☐ MAFLD
- ☐ Gut Health (IBS, IBD, diverticular disease)
- ☐ Food allergies and intolerances
- ☐ Diabetes (Type 2, prediabetes)
- ☐ Prenatal or postnatal nutrition
- ☐ Other: _____

Other Relevant Information: *(please attach the most recent blood work. Referrals submitted without recent results cannot be processed)*

Diagnosis: _____

Medical History

Additional Notes

Thank you for your referral to the Community Care Team. Faxed referrals will be confirmed upon receipt, and consult notes will be provided after the initial consultation, where applicable.

If you have any questions about our programs and services please do not hesitate to contact us.