REFERRAL TO

Comox Valley Nursing Centre
Fax 250.331.8503

Attention: Drop-in nurse of the day

Last Name (print)	First Name	Date of Birth (dd/mm/yyyy)	Telephone:
Address		PHN #: Sex: Male Female	

Reason for Referral:

_____

_____

Requested Services: (Please check)

COMMUNITY PAIN SERVICES

Refer to Primary RN for:

1:1 consultation

Chronic Pain Management Team
GP Pain Consultation
Super 6 Exercise Program

Open Community Services

Chronic Pain Education Series
Chronic Pain Support Group
Relaxation Therapy Program

OTHER SERVICES AT THE NURSING CENTRE

General health consultation with RN
Chronic Disease Management
NI Regional Eating Disorders program (therapy,
nutrition services- Comox Valley only) Nurse Practitioner – Positive Wellness North Island
Men's Peer counselor (Thurs/Fri only)
Street Outreach

OTHER SERVICES

NI Regional Eating Disorders program (counseling services- Campbell River only)

Medical Diagnosis (attach relevant reports):

_____

_____

Current Medications (attach):

_____

_____

Has this client been informed of this referral? ☐ Yes ☐ No

Referred by: _____ Phone #: _____

Clinic or agency: _____ Patients' GP: _____

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