RICHMOND PCN SERVICES REFERRAL FORM

Our team-based approach ensures coordinated patient care.

QUESTIONS? CALL 604-233-5686

RESET FORM

PRIMARY CARE NETWORKS Richmond

REFERRAL DATE: dd/mm/yyyy

PCN SERVICE / TEAM REQUESTED

- ☐ Chronic Disease Management Nurse
- ☐ Clinical Counsellor
- ☐ Clinical Pharmacist
- ☐ Dietitian
- ☐ Frail Seniors Team
- ☐ Occupational Therapist
- ☐ Physiotherapist
- ☐ Social Worker

GENERAL REFERRAL ELIGIBILITY*

- ☐ * Patient is **attached** to referring primary care provider **AND** resides in Richmond **OR** primary care provider's practice is in Richmond
- ☐ * Patient **does not** have an open ICBC/WorkSafeBC/third-party claim
- ☐ Patient **does not** have health benefits plan (extended coverage)

**See Pathways (https://pathwaysbc.ca/clinics/1878) for Richmond PCN service-specific patient eligibility criteria.*

Patients with extended health benefits/ open claims related to referral are not accepted.

REFERRING PROVIDER INFORMATION

Name: * _____

Phone: * _____ Fax: * _____ Email: _____

Preferred contact method(s): ☐ Phone ☐ Text ☐ Email ☐ Fax ☐ Other: _____

Locum name (if applicable): _____

PATIENT INFORMATION

Last name: * _____ First name: * _____

PHN: * _____ DOB: * dd/mm/yyyy Gender: * ☐ M ☐ F ☐ Other: _____

Home address: * _____ City/town: * _____ Postal code: * _____

Preferred phone: * _____ Phone (other): _____ Email: _____

Preferred language: ☐ Cantonese ☐ English ☐ Mandarin ☐ Punjabi ☐ Other: _____

☐ YES, language interpreter required (to be arranged by PCN)

ALTERNATE CONTACT INFORMATION (optional)

Relationship: ☐ Parent/guardian ☐ Family member ☐ Caregiver ☐ Other: _____

Last name: _____ First name: _____

Phone: _____ Email: _____ Notes: _____

REASON FOR REFERRAL

Summarize patient history, relevant diagnoses, risk factors: *

☐ **DO NOT** refer to other PCN services without FP/NP consult

Indicate and attach relevant patient history

☐ Current medications list ☐ Labs / other tests ☐ Relevant clinical notes ☐ Other: _____

___ * TOTAL # PAGES (*not including referral form*)

** indicates required field*

SUBMIT FORM

EMAIL SUBMIT

BY EMAIL
RMDPCN@VCH.CA

BY FAX
604-244-8599

PCN INTERNAL USE ONLY- PARIS ID: _____