Comox Valley Division of Family Practice
A GPSC initiative

Unattached Patient Referral Form

PATIENT INFORMATION Name:		**YEAR** of Birth:
First three digits of postal code:	Home Phone:	OK TO LEAVE A MESSAGE? YES / NO
Cell Phone:	Other Contacts: (eg. Text/leave message w/friend, mail etc) (See Note 5)	

Recent hospitalization? (*within last year*) Yes No If Yes, Name of Hospital_____

Recent ER visit? (*within last 6 months*) Yes No If Yes, Name of Hospital_____

Please indicate which of the following apply to patient *(check all that apply)*

- ☐ Frail in Care
- ☐ Frail in the Community
- ☐ Waiting for Assisted Living/LTC Admission
- ☐ 70+ years old
- ☐ Significant Cancer
- ☐ Mental Health
- ☐ Moderate to High Needs Complex Chronic Conditions
- ☐ Substance Use
- ☐ Severe Disability in the community
- ☐ New mother & infants (from pregnancy to 18 months)
- ☐ Other: (please specify): _____

Timeframe to be seen within:
☐ **3 days** ☐ **14 days**
☐ 2 months ☐ 2 – 6 months

Transportation available?
☐ Yes ☐ No

Please indicate reason patient doesn't have a family doctor?
- ☐ New to community
- ☐ Unable to find a doctor
- ☐ Physician retired/moved
- ☐ Other _____

REFERRAL SOURCE

Name:	Agency/Clinic:	Date Referred:
Do you want to be updated regarding the outcome of the referral? ☐ Yes ☐ No		
Phone Number:	Fax Number:	
Why is this patient being referred (see Note 4)?		

CONSENT: I _____, consent to my name being referred to the Comox Valley Central Referral Mechanism for the purposes of: (a) potentially referring my information to a family physician within the community should one be available and (b) recording non-identifying personal health information for the purposes of evaluating the success of the Central Referral Mechanism project. Should patient not be present, referral source to sign that they have received verbal consent from the patient to make this referral.

Patient/Guardian/Power of _____ Date: _____
Attorney Signature
Witness Signature _____ Date: _____

FOR OFFICE USE ONLY	
Referred to: _____	Physician Office: _____
Date: _____	Attached? ☐ Yes ☐ No
Patient No: _____	Date: _____

Notes: (1) Please fax this form to: 1 866 386 2224. (2) Completion of this form does not guarantee availability of a physician (3) For further information about the referral please call: 250-898-1074. (4) In order to protect patient privacy, only initial information is gathered. Referral source and physician may contact to discuss details. (5) If no contact, referring agency please call 250-898-1074.