

PRIMARY CARE ACUTE SITE DISCHARGE (ED OR HOSPITAL) PROGRAM REFERRAL

A physician will connect with the patient by phone or telehealth following discharge to provide follow-up assessment and connection to community supports, if needed. Any questions can be directed to Erin Carey at erin.carey@fnwdivision.ca.

REFERRAL DETAILS:			
Referral Date:		Patient Name:	
Referral Time:		Patient DOB:	
Referring Institution:	<input type="checkbox"/> RCH <input type="checkbox"/> ERH <input type="checkbox"/> Other: _____	Patient PHN:	
		Patient Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
		Patient Address:	
Referring Provider: <i>If available, please add stamp</i>		Patient Phone Number:	
		Patient Email Address:	
		Is the patient attached to a Family Practitioner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Family Practitioner Name & Phone Number:	
CLINICAL INFORMATION:			
Patient requires follow up for:			
Requested time for follow-up within (NB: must phone for <24hr follow up):	<input type="checkbox"/> < 24 hours <input type="checkbox"/> 3-5 days <input type="checkbox"/> 1-2 days <input type="checkbox"/> Other: _____		
Checklist of additional notes to include: <i>(* = required)</i>	<input type="checkbox"/> Medication List* <input type="checkbox"/> Past Medical History <input type="checkbox"/> Active Medical Issues* <input type="checkbox"/> ER Discharge Report <input type="checkbox"/> Need for extra medical equipment		

Patient consents to being contacted by a physician following discharge, and is aware of the risks inherent in electronic communication

PLEASE FAX TO: 778-623-2006