

Scarborough Doctors FHO Interprofessional Services Referral Form

Carefirst Seniors and Community Services Association

300 Silver Star Blvd, 2nd floor, Scarborough ON, M1V 0G2

Phone: 416-847-8941 Fax: 416-646-5111

SERVICE(S) REQUESTED: ☐ Physiotherapist ☐ Dietitian ☐ Social Work / Mental Health Worker

REFERRAL TO OTHER CAREFIRST SERVICE(S): ☐ Refer to other Carefirst programs/services as appropriate

URGENCY LEVEL: ☐ Urgent ☐ Routine

REASON FOR REFERRAL:

BRIEF MEDICAL HISTORY AND RECENT DIAGNOSIS:

PATIENT INFORMATION:

FIRST NAME: _____ **LAST NAME:** _____

Date of Birth (D/M/Y): _____ **Gender:** ☐ Male ☐ Female ☐ Other: _____

Preferred Language: ☐ English ☐ Other: _____ **Interpreter required?** ☐ Yes ☐ No

Address: _____ **City:** _____

Postal Code: _____ **Health Card Number:** _____

Phone (mobile): _____ **(Alternate):** _____

Email address: _____ **Preferred Contact Method:** ☐ Phone ☐ Email ☐ Either

Patient consents to SMS/email communication (e.g. appointment reminders): ☐ Yes ☐ No

Primary Contact Person (if different from patient): _____

Please attach all relevant supporting documents including patient profile, medication list, consultations, x-ray, CT, blood work, etc.

Signature

Date