Huron Perth Primary Care Nurse Practitioner Program
Referral Information

Information for Referral Source

- Information marked “required” on the referral form must be completed in full
- Information requested on the referral form may be sent as a separate attachment if there is insufficient space on the referral form
- The referral source must inform whether subsequent referrals were made to similar programs to avoid duplication
- Communication regarding service connection will be provided to the referral source via fax and/or telephone

Note: If a referral needs to be cancelled for any reason, please contact the Huron Perth Primary Care Nurse Practitioner Program at 519-527-8421 extension 4818 or by fax 519-527-8420.

Information for Individuals Being Referred

- The individual being referred must be aware that a referral is being made to the Huron Perth Primary Care Nurse Practitioner Program.
- Appointment booking will be communicated via telephone to the patient/caregiver and/or via fax to the referral source.
- If an individual’s contact information changes, they and/or their Substitute Decision Maker are responsible to notify the program or their Primary Care Nurse Practitioner.
- Huron Perth Primary Care Nurse Practitioner Program staff will make three attempts to contact the individual by telephone. If contact cannot be made, the file will be closed and the referral source will be notified.
- Individuals can contact the Huron Perth Primary Care Nurse Practitioner Program to receive an update on the status of their referral by calling the Huron Perth Primary Care Nurse Practitioner Program at 519-527-8421 extension 4818.

How to Submit the Huron Perth Primary Care Nurse Practitioner Referral Form

- Fax the completed Referral Form to **519-527-8420** (each referral must be faxed separately)
- To help us provide the best care possible, please complete all pages of the referral form and include all relevant documents, such as previous psychiatric consultations, discharge summaries, medication administration records, psychological/mental health notes, lab and test results, and medical information.

If an individual is in crisis, direct them to the **Huron Perth Helpline and Crisis Response Team** at **1-888-829-7484** or their nearest Emergency Department. If an individual is experiencing an emergency, **9-1-1** should be contacted.

If you have any further questions or concerns, please contact the Huron Perth Primary Care Nurse Practitioner Program at 519-527-8421 extension 4818. Please **do not** contact the Primary Care Nurse Practitioner directly to follow-up on referral status.

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Referral Form

Date of Referral: _____ *(DD/MM/YYYY)* Date Referral Received ***(office use only)***: _____

Referral and Criteria Checklist – Required (must meet all criteria identified)

☐ **Huron Perth Primary Care Nurse Practitioner Program**
- ☐ 16 years of age and older
- ☐ Experiencing complex medical concerns or mental health and/or substance use concerns
- ☐ Currently without a Primary Care Provider
- Resident of ☐ Huron **or** ☐ Perth County

☐ **Homeless Access to Care**
- ☐ Experiencing homelessness
- ☐ Currently without a Primary Care Provider
- Resident of ☐ Huron **or** ☐ Perth County

Is the patient and/or Substitute Decision Maker/Caregiver aware of this referral: ☐ Yes ☐ No

Does the patient and/or Substitute Decision Maker/Caregiver consent to this referral: ☐ Yes ☐ No

Please note, the patient and/or Substitute Decision Maker/Caregiver must consent to a referral being made on their behalf to Huron Perth Primary Care Nurse Practitioner Program.

Patient Demographic Information – Required *(please print)*

Patient's Legal Name *(first name, last name)*: _____

Preferred Name *(if different from above)*: _____

Date of Birth *(DD/MM/YYYY)*: _____ Sex Assignment at Birth: ☐ Male ☐ Female ☐ Intersex

Gender Identity: _____ Pronouns: _____

Health Card Number: _____ Version Code: _____

Address: _____ ☐ No Fixed Address
(Street, Town, Province, Postal Code)

Telephone: _____ *(home/cell/work/other)*

Consent to contact by telephone: ☐ Yes ☐ No Consent to leave detailed voicemail: ☐ Yes ☐ No

Consent to speak with others in the household: ☐ Yes ☐ No

If yes, please specify *(name/relationship)*: _____

Living Arrangements *(self, spouse, parent(s), long-term care, group home, roommate(s) etc.)*: _____

Additional Considerations

☐ Mobility ☐ Audio ☐ Visual ☐ Language ☐ Interpreter Services Required ☐ Service Animal

☐ Other: _____ If yes, please explain: _____

Substitute Decision Maker / Caregiver Information *(if applicable)*

By providing this information, the Referral Source confirms that the individual being referred consents for the HPHA to call the Substitute Decision Maker/Caregiver on their behalf. The HPHA will refrain from communicating Personal Health Information until consents are verified.

Name of Substitute Decision Maker / Caregiver: _____

Relationship to patient: _____

Telephone: _____ *(home/cell/work/other)*

Consent to leave detailed voicemail: ☐ Yes ☐ No

Referral Source Information - Required

Name/Agency/Program: _____

Address: _____

Telephone:_____ Fax:_____

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Mental Health Services involved in the Past 5 Years – Required *(attach if details cannot fit in the space provided)*

Organization Name: _____

Current Involvement: ☐ Yes ☐ No If yes, describe involvement: _____

Date of Most Recent Psychiatry Assessment: _____

Psychiatry Assessment Completed by: _____

Psychosocial, Accommodation or Risk Factors *(if applicable)*

Provider Safety Concerns / Home Visit Concerns

Are there any known safety risks staff should be aware of in delivering service? *(such as history of violence/aggression, history of sexual assault, access to weapons, domestic violence, current or recent substance use, smoking in the residence, animals in the residence)*:

Presenting Concerns – Required *(attach if details cannot fit in the space provided)*

Please provide a brief narrative explaining presenting concerns and symptoms, including duration and frequency of symptoms, psychosocial factors, substance use issues, patient safety concerns, and all other current and historical information that is relevant:

Medical/Physical Health - Required

Please provide a list and details of any relevant medical/physical considerations (e.g. specific illnesses, chronic pain, difficulty coping with medical illness, etc.)

Allergies: ☐ Yes ☐ No If yes, please specify: _____

Medications - Required ☐ **attached**

Please include both psychiatric and non-psychiatric medication (dose, frequency, adverse effects), including all current and previously trialed medications. Please attached a medication list if the medications are expansive of the space provided.

Please attach any other relevant information for this referral.

_____

Name *(Professional, Self or Caregiver)*

_____ _____

Signature *(Professional, Self or Caregiver)* **Date** *(DD/MM/YYYY)*

Thank you for making a referral to the Huron Perth Primary Care Nurse Practitioner Program. Your involvement in this patient's care is important to us; if you have any questions or concerns, or wish to provide updated patient information, please contact the Huron Perth Primary Care Nurse Practitioner Program at **519-527-8421 extension 4818** or **by fax 519-527-8420**.