HURON PERTH ONTARIO TELEMEDICINE NETWORK
PRIMARY CARE NURSE PRACTITIONER PROGRAM

Servicing Patients within the Huron Perth Addictions & Mental Health Alliance ages 16 and over (those under the age of 16 may be considered in special circumstances at NPs discretion). **These individuals must be without a primary care provider.**

Today's Date:___________

Patient Name:____

DOB: ______________________________ Gender:_______________

Health Card # ___________________ Version Code:__________

Patient Phone #:________________________

Address: ____
(STREET ADDRESS, SUITE, POSTAL CODE)

Emergency Contact/Next of kin: ________________ Phone#:__________

Instructions for Contacting Client:________________________________
____

Able to leave voice message: Y__ N__

Primary Care Provider (if applicable): ____________________________

Please note that the person completing this referral shall contact the primary care provider to inform him/her of this referral
Medical Problems: ____
____
____
____

Referred by:___________________ Agency:_________________________

Contact #_______________________ Ext.________ Fax #:_____________

Psychiatrist name (if applicable):___________________________________

Mental Health Diagnosis:
____
____

Current Mental health services and lead name:
____

Reason for referral:____
____
____

Current Medications (please ask patient to bring all of their current medications, including supplements with them to the appointment)

Please attach a list of patient medications from a pharmacy or medication reconciliation

Pharmacy:__________________________ City:_________________________

Phone:______________________ Fax:________________________

Allergies:____
____

Other pertinent information:
____
____

Safety Concerns for providers:____
____

Current/Past Criminal Charges: _______________________________________
____

Referrals can be faxed to 519-527-8420. For more information please contact 519-527-8421 ext.4800.

It will be the responsibility of the referring party to contact the client with the initial appointment time.

Patients must be accompanied by a mental health worker to their initial appointment.

Please attach medical history, current medication list, lab results, and any information which may be relevant to this referral. – *thank you*