Couchiching Ontario Health Team
Chronic Disease HUB Central *REFERRAL*
for Health Care Providers

FAX: 705-325-8148 PHONE: 705-329-3649 Ext 160

*We do NOT provide emergency or crisis services *Incomplete referrals will delay processing
*Questions? Please call 705 329-3649 EXT 160

PATIENT INFORMATION

Last name: First name: Preferred name:
Address: Email Address:
Phone Number: Alternate Phone Number:
DOB (dd-mm-yy) Gender:
Health Card with Version Code:
Preferred Language: Interpreter Required: ☐ Yes ☐ No
French Language Services Required: ☐ Yes ☐ No
Identify as First Nation, Inuit, Metis, Urban indigenous: ☐ Yes ☐ No
Primary Care Provider:
Alternate contact Information:
Contact person for appointment: ☐ Patient ☐ Alternate Contact
Contact Name: Phone Number: Relationship:

Referral Priority COPD / CHF

☐Urgent <2 weeks (ie recent hospitalization, ED visit, exacerbation)
☐Semi-Urgent 2-4 wks ☐Non-Urgent 6-8wks

Program Requested:

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Is COPD diagnosis confirmed with spirometry?

☐ NO, if clinically suspected of having COPD we may refer for Spirometry

☐ **Spirometry ONLY** ***please ensure patient has been prescribed Salbutamol/Ventolin MDI with Aerochamber/Spacer to bring with them for testing.***

☐ YES, please include PFT/Spirometry results and indicate services requested:

☐ **Repeat Spirometry** ***please ensure patient has been prescribed Salbutamol/Ventolin MDI with Aerochamber/Spacer to bring with them for testing.***

☐ **Comprehensive COPD Team** (Medical Management, COPD Action Plan, Medication Review, Education, Advanced Care Planning, Smoking Cessation)

Please indicate support needed e.g. assess inhaler adherence/recent hospital discharge

☐ **Pulmonary Rehab** Including exercise (criteria based)

☐ **Respirologist Consultation for high risk patients*** (see criteria below)

****Referral required from a Primary Care Provider (MD/NP) for Respirologist**
Eligibility criteria for Respirologist consultation for high-risk COPD patients;
(Please check at least one of the following)

☐ PFT/Spirometry with “severe” or “very severe” obstructive defect
☐ Persistent daily uncontolled symptoms despite treatment with maximal inhaler therapy (ICS/LABA/LAMA) as indicated by CAT score >10.
☐ Frequent exacerbations (>2 ER visits/hospital admissions per year or >2 Rx for prednisone/antibiotics per 6-months) despite maximal inhaler therapy (ICS/LABA/LAMA)
☐ Chronic CO_2 retention (elevated CO_2 on ABG/VBG or elevated bicarbonate to suggest so)
☐ Chronic hypoxic respiratory failure (on home oxygen)
☐ Palliative care need (considering need for opiates for dyspnea)

CONGESTIVE HEART FAILURE (CHF)

THIS PROGRAM IS FOR PATIENTS DIAGNOSED WITH CONGESTIVE HEART FAILURE

☐ **Comprehensive CHF Team including Specialist** (Medical Management,CHF Action Plan, Medication Review, Education, Advanced Care Planning)
****Referral required from a Primary Care Provider (MD/NP) for HF Specialist**

Indicate how Heart Failure has been diagnosed. Please confirm and attach findings:

☐ Echo ☐Cardiac Catheter ☐X-Ray Results ☐NTproBNP

Brief history of diagnosis:

To expedite referral, *MUST INCLUDE THE FOLLOWING* (check all attached):

☐ **CPP**
☐ **Diagnostic Tests (ie PFT, ECHO, Cardiac Catheter, Imaging, NTproBNP)**
☐ **Blood work**
☐ **Medication Profile**
☐ **Office notes/ tests**
☐ **Pertinent Consult Reports**

CONSENT ☐ Yes, verbal consent obtanied FROM: ☐ Patient ☐ SDM or POA

Patient/SDM/POA is aware of the role of central intake in the collection, use and disclosure of personal health information (PHI) with health service providers to assist with the care of the referred patient.

Patient/SDM/POA understands that they can withdraw consent at any time with all or a subset of service providers with no penalty. The withdrawal of consent does not have retroactive effect, nor does it affect the uses and disclores of PHI collected by central intake as permitted or required by law wihtout consent.

REFERRAL SOURCE INFORMATION:

Name of Referring Source: ______________________________

Physician☐ER ☐ Hospitalist ☐ Primary Care Provider Billing #:

Nurse Practitioner ☐ Billing #:

Other, please identify:

Phone Number: Fax Number:

Signature:

Primary Care Practitioner Name: ________________________________

Is the PCP aware of referral ☐ Yes ☐ No