Grand River Community Health Centre

Interprofessional Primary Care Team (IPCT) Referral Form for Providers

Provider information

Name _____ Date (mm/dd/yyyy) _____

Organization Name _____

Phone _____ Fax _____

Client information

Name _____ Date of birth (mm/dd/yyyy) _____

Address _____City _____

Postal Code _____Health Card _____

Phone _____Email_____

Client pronouns are: ☐ She/Her ☐ He/Him ☐ They/Them

Please check off the primary reason for the referral:

Group Programs:

- □ Heart Health – blood pressure and cholesterol education
- □ Prediabetes/Diabetes
- □ Caring for my COPD

Individual support:

- □ Nutrition counselling (Care provided by Registered Dietitians) – Nutrition education for clients across the human lifespan and goal setting to improve health
- □ Mental health counselling – Supporting individuals with developing positive coping strategies and achieving overall mental wellness
- □ Social prescribing – Assisting clients with connecting to non-clinical resources and services to improve social connection and well-being
- □ Diabetes Program (Care provided by Certified Diabetes Educators) – Helping individuals gain the knowledge and skills to effectively self-manage type 2 diabetes and providing recommendations to the referring provider when required (Please include most recent lab work if available).

Other reason for this referral: _____

_____

Please attach any relevant health information, including medical history, medications, and lab work.

Please Fax referral to 519-754-0757 Attn: IPCT Program