Timmins
Family Health Team
Équipe de Santé Familiale

Palliative Primary Care Program
External Referral Form

Forms can be mailed, dropped off or faxed to the following address:

Timmins Family Health Team Attn: Patient Navigator, Suite 300-123 Third Ave, Timmins, ON P4N-1C6 **Fax:** 705-267-1796

Referred by: _____ Phone: _____ Date of Referral: _____

Priority (time to be seen) ( ) 1-2 days ( ) 3-5 days ( ) 7 to 10 days ( ) > 10 days

Reason for Referral: *Check all that apply*

Primary Care Provider: ( ) Requiring Palliative PCP MD or NP ( ) Transfer of Care to Palliative PCP

MD Consultation for: ( ) Pain ( ) Symptoms management _____ ( ) other _____

Other Services: ( ) Patient Navigator Consult/Support
( ) SW Consult (FHT only, otherwise refer to CCAC SW) Reason:_____
( ) Nutrition Consult (FHT only, otherwise refer to CCAC Nutrition) Reason:_____
( ) Bereavement
( ) Volunteer Visitor Program (Horizon Timmins)

Name:		Health Card# VC	
Address:		Postal Code:	
Phone:	Gender: ( ) Male ( ) Female	D.O.B: M/D/Year	
Present Location:	Informed of referral:	Allergies:	
Primary Diagnosis:		Date of Onset:	
Secondary Diagnosis:		PPS:	
Family Physician/MRP:	**Informed of referral:**	Phone:	Fax:
Specialist:	Phone:		
Pharmacy:	Phone:	Fax:	
CCAC CM: Phone & Ext:	Nursing Agency:	Phone:	
Next of Kin/Contact Person		Power of Attorney of Care Y___ N___	
Name:		Relationship:	
Address:		Postal Code:	
Telephone: Daytime:		Evening:	
Additional information:			

Please attach any recent notes and medication list if possible