HPCN Specialty Health Team Referral Form

The Highland PCN has specialty health team members working as an extension of the medical home to provide consults for specific complex patient needs, as outlined below. **Help us support your patients in the most efficient way possible by providing the necessary information. *Please note incomplete forms might be sent back for clarification.**

Name:_____
PHN: _____
DOB: _____
Address: _____
Phone #: _____
Family physician: _____

Referred by:_____

Date: _____

1. **Please check reason for referral**: Please note, if you don't see what you need here, please consider having the patient see your RN or SW in your office to help navigate the patient to additional PCN or community programs.

☐ **Ambulatory Blood Pressure**

Dietitian	Kinesiologist	Pharmacist
☐ **Celiac** ☐ **Allergy / Intolerance** ☐ **Gastro-intestinal (IBS)** ☐ **Malnutrition** ☐ **Unexplained weight loss** ***Please note, obesity or weight management patients should be referred to the PCNs Health Improvement Program (HIP)**	☐ **Exercise plan for chronic health conditions e.g. arthritis** ☐ **Balance/Falls concerns** ☐ **<u>This patient has been evaluated for risk and is medically stable to proceed with exercise</u>**	☐ **Comprehensive medication review (including post hospital discharge)** ☐ **Medication reconciliation** ☐ **Deprescribing/simplify medication therapy** ☐ **Opioid titration** ☐ **Pre surgical medication advice** ☐ **Suggest/confirm medication therapy** ☐ **Other complex needs**

2. **Please provide additional details specific to reason for referral:** _____

_____

_____

3. **Please include the following clinical information that will aid our assessment:**

☐ **Complete medication list**
☐ **Medical conditions**
☐ **Allergies**
☐ **Most recent chart note prompting reason for referral**
☐ **Any other pertinent information**