MEDICALLY COMPLEX PATIENTS (MCP) OUT-PATIENT REFERRAL FORM

Part 1: Demographics (To be completed by ward clerk or hospital patient sticker or MCP staff):

TEL: 416-284-6168 <u>OR</u> 416-757-3237 FAX: 416-673-9369

Complex Patient Project Right Place	Alme
East GTA Family Health Team Supporting the Transition	
amplearing are married	

Date (MM/DD/YY)		
Name (Last)		
Birth Date (MM/DD/YY)	Health Card #	
Address	City	Postal Code
Phone: (Home)	_ (Work)	(Cell)
Email	Marital Status:	(Cell) How many children:
Next of Kin: Name	(phone	e)
		e)
Guardian/Parent (Name)	(Phone	e)
PART 2: Medical Diagnosis (To be cauthorized representative): Reasons for Referral:		sician /Family Physician OR their
Dx:		
Existing Health Concerns/Comorbid	lities:	
□ COPD	☐ Stroke / TIA	Recent pneumonia < 1 YR
☐ CHF	☐ Cancer	☐ Dialysis: Peritoneal/Hemo
□ HTN	☐ Chronic pain	☐ Vision Impaired
	·	☐ Hearing Impaired
☐ CAD / MI / A.Fib	Li Dementia/Aizneimer	i Licaring Inipaneu
☐ CAD / MI / A.Fib	☐ Dementia/Alzheimer ☐ Parkinson's Disease	
☐ CKF/CRF	☐ Parkinson's Disease	☐ Speech impaired
		☐ Speech impaired
☐ CKF/CRF ☐ Diabetes ☐ Obesity OTHER ISSUES: CCAC Pre-Discharge Referral Comple	□ Parkinson's Disease □ Other mental health issues eted: YES / NO DATE	Speech impaired S Mobility impaired (MM/DD/YY):/
☐ CKF/CRF ☐ Diabetes ☐ Obesity OTHER ISSUES: CCAC Pre-Discharge Referral Comple	Parkinson's Disease Other mental health issues eted: YES / NO DATE SIGNATURE:	Speech impaired S Mobility impaired (MM/DD/YY):/
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