# Integrity Senior Care

RN-Led Transitional and Complex Care Support

London, Ontario | Payal, RN, BScN

# Clinician Referral Form

Licensed with the College of Nurses of Ontario | ACLS Certified | PHIPA Compliant | Fully Insured

## REFERRING CLINICIAN

Clinician Name *

Role / Title *

- [ ] Family Physician
- [ ] Specialist
- [ ] Nurse Practitioner
- [ ] Discharge Planner
- [ ] Social Worker
- [ ] Other

Clinic, Hospital, or Organization *

Phone Number *

Email Address *

Preferred Contact Method

- [ ] Email
- [ ] Phone
- [ ] Fax

Fax Number (if applicable)

Best Time to Reach You

## PATIENT INFORMATION

Patient First Name *

Patient Last Name *

Date of Birth (YYYY-MM-DD) *

Health Card Number (optional)

Patient Address *

Patient or SDM Phone Number

Living Situation

- [ ] Private home (alone)
- [ ] Private home (with family)
- [ ] Retirement residence
- [ ] Other

## CLINICAL INFORMATION

Primary Diagnosis or Reason for Referral *

Secondary Diagnoses

Discharge Date (if applicable) YYYY-MM-DD

Discharging Facility

Referral Type (select all that apply) *

- [ ] Post-discharge transitional care
- [ ] Medication reconciliation
- [ ] Injection or infusion support
- [ ] Family guidance and care coordination
- [ ] Chronic disease monitoring
- [ ] Wound care
- [ ] Ostomy management
- [ ] Other

## CLINICAL INFORMATION (CONTINUED)

Current Medications (or note that a list is attached)

Known Allergies

Clinical Notes and Additional Context

Urgency of Referral *

- ○ **Urgent** — Within 24 hours
- ○ **Semi-Urgent** — 48 to 72 hours
- ○ **Routine** — Within the week

## DOCUMENTS TO ATTACH

Indicate which documents you will send separately by fax or secure email. This form acts as the cover sheet.

- ☐ Discharge summary
- ☐ Recent consult notes
- ☐ Goals of care or advance directive
- ☐ Medication list
- ☐ Lab or diagnostic results

**Fax:** (226) 884-6767 **Email:** contact@integrityseniorcare.ca

## CONSENT AND ACKNOWLEDGEMENT

By submitting this referral, I confirm that I have obtained, or have reasonable grounds to believe that the patient or their substitute decision maker has consented to the sharing of this information for the purpose of care coordination. This referral is submitted in accordance with PHIPA and applicable privacy legislation.

☐ I confirm the above and consent to share patient information for care coordination purposes. *

Clinician Signature

Date (YYYY-MM-DD)