Greater Sudbury Health Link Referral Form

This referral form will assist in identifying those who are eligible for Greater Sudbury Health Link coordinated care planning. ***Some sections of this referral will require the input of the patient/individual.***

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| Demographic Information  |
| Name:  |
| Date of birth (dd/mm/yy):  |
| Age: | Gender:  |
| Health Card Number: | No valid Health Card[ ]  |
| Address: |
| Phone: |
| Preferred method of contact: |
| Mother tongue: | Preferred official language:  | Ethnicity/Ancestry: |
| Secondary contact name: |
| Relationship to individual: | Secondary contact phone: |
| Referral Source  |
| Name of agency/primary care provider: |
| Contact person: | Phone: | Fax: |
| ***Note to physicians and primary care providers:*** *Please provide the phone number where you can be most easily contacted by the Greater Sudbury Health Link Liaison.* |

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*Do not proceed with the collection of information without individual’s consent to proceed with a referral to the Greater Sudbury Health Link. If individual declines consent, please keep this document on your agency file for reference.*

**Greater Sudbury Health Links Target Population** (This is not an exclusive or exhaustive list. Clinical judgment should be used when considering potential referrals. Check all that apply)

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| Eligibility Considerations |
| [ ]  | Mental illness (suspected or diagnosed) |[ ]  Frequent ED visits, hospitalizations, EMS calls and/or visits to primary care providers |
| [ ]  | Substance addiction | [ ]  | Chronic disease, physical co-morbidities and/or high cost conditions (see checklist on page 3) |
| [ ]  | Developmental disability | [ ]  | Cognitive challenges/decline; Acquired Brain Injury |
|  |  | [ ]  | Social and/or economic stress factors (see checklist below)  |
|  |  | [ ]  | Complex responsive behaviours that are impacting the individual’s health and well-being |

**Health and Social Conditions Checklist** (check all that apply)

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| Social And Economic Stress Risk Factors |
| [ ]  | Low Household Income |[ ]  Household in Need of Repair |
| [ ]  | Living Alone | [ ]  | Low Education Level |
| [ ]  | Lack of family or social supports | [ ]  | Recent Immigration |
| [ ]  | No Knowledge of Official Languages | [ ]  | Other:  |
| [ ]  | Unemployment | [ ]  | Other:  |
|[ ]  Homelessness | [ ]  | Other:  |

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| Health Conditions |
|[ ]  ALS (Lou Gehrig’s Disease) |[ ]  Depression |[ ]  Mental Health Conditions (unspecified/unknown) |
|[ ]  Amputation |[ ]  Developmental Disorders |[ ]  Multiple Sclerosis |
|[ ]  Anxiety Disorders |[ ]  Diabetes |[ ]  Muscular Dystrophy |
|[ ]  Arthritis and Related Disorders |[ ]  Eating Disorders |[ ]  Osteoporosis including Pathological Bone Fracture |
|[ ]  Asthma |[ ]  Epilepsy & Seizure Disorders |[ ]  Other Perinatal Conditions |
|[ ]  Bipolar |[ ]  Fracture |[ ]  Pain Management |
|[ ]  Blood Disorders (anemia, coagulation defects |[ ]  Hernia |[ ]  Palliative Care |
|[ ]  Brain Injury |[ ]  Hip Replacement |[ ]  Paralysis & Spinal Cord Injury |
|[ ]  Cardiac Arrhythmia |[ ]  HIV/AIDS |[ ]  Peripheral Vascular Disease & Atherosclerosis |
|[ ]  Cerebral Palsy |[ ]  Huntington’s Disease |[ ]  Personality Disorders |
|[ ]  Chronic Obstructive Pulmonary Disease |[ ]  Hypertension |[ ]  Pneumonia |
|[ ]  Coma |[ ]  Influenza |[ ]  Renal Failure |
|[ ]  Congenital Malformations |[ ]  Ischaemic Heart Disease |[ ]  Schizophrenia & Delusional Disorders |
|[ ]  (Congestive) Heart Failure |[ ]  Knee Replacement |[ ]  Sepsis |
|[ ]  Crohn’s Disease/Colitis |[ ]  Liver Disease (Cirrhosis, Hepatitis, etc.) |[ ]  Stroke |
|[ ]  Cystic Fibrosis |[ ]  Low Birth Weight |[ ]  Substance Related Disorders |
|[ ]  Dementia |[ ]  Malignant Neoplasms (cancer) |[ ]  Transplant |
|[ ]  Other:  |[ ]  Other:  |[ ]  Ulcer |

**Reason for Referral** (Main concern, diagnosis, chronic disease condition, mental health condition, social risk factors, recent trigger/escalation):

**Other agencies/primary care provider/services involved** (if known)

**Recommended Greater Sudbury Health Link Liaison** (**Select one of the following** based on the individual’s existing connections with care providers, needs, goals, and/or preferences. This agency will confirm the individual’s participation, work with the individual to start their GSHL Coordinated Care Plan, and coordinate their first Care Team Conference. Referred individuals do not need to have existing connections with their selected Liaison agency. The ongoing Lead Care Coordinator for this individual will be determined in consultation with their full care team.)

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| Greater Sudbury Health Link Liaison Agencies |
| [ ]  | **Canadian Mental Health Association – Sudbury/Manitoulin** – mental health case management and supports  |[ ]  **North East Community Care Access Centre** – coordinators of home and community based health services *(select only if the individual is currently receiving service from NECCAC)* |
| [ ]  | **Centre de santé communautaire du Grand Sudbury** – francophone community health centre | [ ]  | **Sudbury Community Service Centre** – supporting adults with developmental disabilities |
| [ ]  | **Monarch Recovery Services** – addiction recovery services and supports | [ ] [ ]  | **Réseau ACCESS Network** – HIV Supports**Réseau ACCESS Network** – Hepatitis C Supports |
| **Health Sciences North – Mental Health & Addictions Programs**  |
| [ ]  | Assertive Community Treatment Team | [ ]  | Positive Steps Program |
| [ ]  | Developmental Clinical Services | [ ]  | Primary Care and Medication Support |

**Other important information –** *please include* ***relevant******and current*** *legal and safety concerns* (strengths, historical information, etc.)

**Documented Consent**

|  |  |
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| **The referred person consents to the following:** | **Yes/No** |
| Their personal health information being collected and stored by the North East Community Care Access Centre |  |
| Their personal health information being stored by the Canadian Mental Health Association – Sudbury/Manitoulin as lead agency for the GSHL  |  |
| The information contained on this form being shared with their identified Greater Sudbury Health Link Liaison (see list above) |  |
| Being contacted by their identified Greater Sudbury Health Link Liaison (see list above) |  |
| A message being left for them by their Greater Sudbury Health Link Liaison (see list above) |  |

I confirm that I have received the above verbal consents:

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Name of referring provider Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date