Telemedicine IMPACT Plus (TIP) Referral Form

Interprofessional Clinic for Patients with Complex Care Needs

Referral Source:

Date of Referral (mm/dd/yy): _____

Referral Source Name: _____

Phone №: _____

Primary Care Provider Name: _____

Street Address: _____

Postal Code: _____ Phone №: _____ Fax №: _____

OHIP Billing №: _____ Email: _____

Patient Demographics:

Patient Last Name: _____ Patient First Name: _____

OHIP №: _____ VC: _____ DOB (mm/dd/yy): _____

Gender: _____ Telephone №: _____

Address: _____

Postal Code: _____ Major Intersection: _____

Can we leave messages at this number? Yes ☐ No ☐ _____

If applicable, name of Substitute Decision Maker (SDM): _____

SDM Relationship: _____ Telephone №: _____

Referral Checklist:

1.	Yes ☐	No ☐	Unknown ☐	Patient consents to participate in TIP
2.	Yes ☐	No ☐	Unknown ☐	Interpreter Required. Language: _____
3.	Yes ☐	No ☐	Unknown ☐	Five or more medications prescribed
4.	Yes ☐	No ☐	Unknown ☐	Two or more chronic conditions present
5.	Yes ☐	No ☐	Unknown ☐	Care is difficult to manage due to complications of co-existing conditions
6.	Yes ☐	No ☐	Unknown ☐	Cognitive impairment concerns
7.	Yes ☐	No ☐	Unknown ☐	Mental health or substance use issues
8.	Yes ☐	No ☐	Unknown ☐	Frequent hospital/emergency department visits
9.	Yes ☐	No ☐	Unknown ☐	Patient has been diagnosed with diabetes
10.	Yes ☐	No ☐	Unknown ☐	Patient receives services from Home and Community Care
11.	Yes ☐	No ☐	Unknown ☐	Patient receives end of life care

Are you aware of any precautions staff should take when visiting the patient's home? Yes ☐ No ☐ Unknown ☐

if yes, please describe: _____

Priority issues—List concerns you would like addressed during this 1-hour consult:

_____

_____

_____

Please fax completed form to 1(888)401-6675