

CLINIC USE ONLY	
Date Received _____	DD/MM/YY
Urgency _____	
Acuity _____	

Interprofessional Primary Care Team Referral Form

PATIENT INFORMATION						
Name		Health Card Number	Work Phone			
Address		Gender Identity	Home Phone			
		Date of Birth <small>DD/MM/YY</small>	Mobile Phone			
Patient informed of Referral <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this the patient's first referral for IPC Team care? <input type="checkbox"/> Yes <input type="checkbox"/> No				
CLINICAL INFORMATION (Please check all that apply)						
Reason for Referral <input type="checkbox"/> Comprehensive Assessment <input type="checkbox"/> Treatment Management <input type="checkbox"/> Other _____						
Urgency <input type="checkbox"/> Immediate <input type="checkbox"/> First Available Reasons: _____						
MENTAL HEALTH DIAGNOSIS/SYMPTOMS						
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		Other Relevant Information 				
				Current Treatment	Yes	No
				Psychotherapy	<input type="checkbox"/>	<input type="checkbox"/>
				Medication	<input type="checkbox"/>	<input type="checkbox"/>
				Psychiatry _____		
				Evaluation Scores		
				GAD-7	<input type="text"/>	<input type="text"/>
				PHQ-9	<input type="text"/>	<input type="text"/>
				Is the patient attached to any of the following?	Yes	No
				Counselling Services	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatry Services	<input type="checkbox"/>	<input type="checkbox"/>				
Workplace EAP	<input type="checkbox"/>	<input type="checkbox"/>				
Home and Community Care	<input type="checkbox"/>	<input type="checkbox"/>				
Physician Name	Signature	Date				
Address		Tel				
		Fax				
Please attach any relevant clinical reports (previous consultation notes and clinical evaluation results).		In order to serve your clients better, the Interprofessional Primary Care (IPC) Team would like to initiate referrals to other healthcare professionals within the IPC Team and Carea programs based on client goals. <input type="checkbox"/> Please check here if you agree to referrals to other services.				

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EXCLUSION CRITERIA - IPC PROGRAM

1. Patients who are actively suicidal/homicidal or have a clear plan
2. Severe anxiety/agitation
3. Acute psychosis or uncontrolled bizarre behaviour
4. Concern for patient's welfare – acute conflict or unstable
5. Acutely intoxicated

PATIENT ACCEPTANCE CONDITIONS

Clients with:

1. Mental health conditions that can be supported by an interprofessional team approach.
2. Social economic characteristics that are a barrier to accessing care.
3. Complex health needs that can benefit from integration of medical management and social support services.

IPC TEAM MEMBERS

Role	Practice Description
Nurse Practitioner	<ul style="list-style-type: none"> • Provides comprehensive collaborative short-term primary care and clinical assessment, treatment and referral to internal/external agencies of clients • Coordination of care of referred clients
Therapist	<ul style="list-style-type: none"> • Conducts biopsychosocial assessments and provides evidence-based psychotherapeutic counselling interventions (e.g. Cognitive Behaviour Therapy, Dialectical Behaviour Therapy, Solution Focused Brief Therapy, Motivational Interviewing, etc.) for referred clients • Develops comprehensive care plans with internal/external agencies
Health Promoter	<ul style="list-style-type: none"> • Supports client by linking clients to internal/external community programs • Delivers health promotion programs and activities that respond to clients' needs, build on strengths and inspires change
Nurse Navigator	<ul style="list-style-type: none"> • Provide comprehensive time limited primary care interprofessional support from a harm reduction framework • Reviews and conducts mental health referrals/triage, provides clinical assessments and interventions • Provides case management, system navigation, support and counselling with internal/external agencies, form completion, advocacy, life-skill development and health education • Conducts home/community visits as needed