Montfort

CHRONIC DISEASE MANAGEMENT CLINIC
Referral form

Fax referral to **613-688-1086**

Patient's identification

FOR ONTARIO RESIDENTS ONLY

PRIORITY (CHOOSE THE APPROPRIATE RANGE)

❑ Urgent* ❑ Non-Urgent

*If urgent, please indicate reason:

AT LEAST 2 COMORBIDITIES and/or	VULNERABILITIES
❑ Chronic obstructive pulmonary disease (COPD)	❑ Mobility/falls
❑ Heart failure	❑ Caregiver stress
❑ Coronary disease	❑ Mood/Depression
❑ Atrial fibrillation	❑ Anxiety
❑ HTN	❑ Continence
❑ Diabetes	❑ Polypharmacy
❑ Chronic kidney disease (CKD)	❑ Pain
❑ Stroke	❑ Nutrition concerns
❑ Cirrhosis	❑ Functional decline
❑ Mild cognitive impairment	❑ Safety
❑ Arthritic conditions	
❑ Other : _____	

REASON FOR CONSULTATION

❑ Difficulty stabilizing their symptoms related to multimorbidity
❑ Difficulty with optimizing their functional status and quality of life
❑ Difficulty with self-management of their chronic diseases
❑ Problems with service coordination and access to appropriate services
❑ Mental health problems and sleep difficulties related to their multimorbidity (anxiety, depression, adjustment difficulties) * please specify in additional information box below
❑ Needs support with proactive advance care planning/resuscitation status
☑ Consultation with interprofessional team:

✓ Physiotherapist ✓ Occupational Therapy ✓Pharmacist
✓ Social Work ✓ Nursing ✓ Dietitian

Additional information:

82000525

NAME OF REFERRING PHYSICIAN: _____.

SIGNATURE: _____.

BILLING NUMBER: _____.

DATE: _____.