Chronic Disease Prevention and Management Hub
Referral Form For CHF and/or COPD

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Phone: 437-562-3847 **Fax:** 1-833-665-5140 **Email:** CDMHub@nygh.on.ca

Please **FAX** or **EMAIL** this form with the CPP, any relevant recent lab results, diagnostic imaging, and consult reports.

Reason for Referral:	**Chronic Disease Management:** ☐ Diagnosed (Management) ☐ At Elevated Risk (Prevention) Please select: ☐ **COPD** ☐ **CHF**	
	☐ Dietary and nutrition counselling ☐ Smoking cessation support and management ☐ Medication review, inhaler use education	☐ Health/chronic disease education ☐ Exercise and rehab referrals ☐ Advance care planning
	☐ **Care Navigation Supports** (e.g. recreation activities, management of ADLs/iADLs, food security, housing)	

Client Information

Last Name:	**First Name:**	Middle Name:
Preferred Name:	**Date of Birth (DD/MM/YYYY):**	**Gender:** ☐ Male ☐ Female ☐ Other
Health Card Number: (Health Card not Required) Version Code:		**Preferred Language:**
Address: Unit #	Street Address	
City		Postal Code
Phone Number:		**Preferred Method of Contact:**
Email Address:		☐ Phone ☐ Email ☐ Mail ☐ Other: _____
Alternative Contact Information: Name: Phone Number:		**PCP Info** (Name, Fax Number, Address): Is PCP Aware of Referral? ☐ Yes ☐ No

Referral

Is the client currently enrolled in cardiac or pulmonary rehab, or receiving ongoing care from any specialist or chronic disease program for their CHF and/or COPD? Please specify.	
Additional Referral Notes: ☐ This is an **urgent** referral (<2 Weeks)	

Referral Source

Name:		Role/Organization:	
Phone Number:		Fax Number:	
Referrer's Signature:		Referral Date: (DD/MM/YYYY)	

Our staff will contact you within 3 business days to confirm that the referral has been received.

We will contact the client directly with an appointment date and time.