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

NORTH YORK TORONTO HEALTH PARTNERS
COMPASSIONATE NORTH YORK

CDM COMMUNITY HUB
CHRONIC DISEASE MANAGEMENT HUB

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:	☐ Diagnosed (Management) ☐ At Elevated Risk (Prevention) Please select: ☐ COPD ☐ CHF ☐ 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:	Version Code:	Preferred Language:
Does the client use any mobility aids? ☐ No ☐ Walker ☐ Wheelchair ☐ Other: _____		
Address: Unit #	Street Address	
City		Postal Code
Phone Number:	Email Address:	
Alternative Contact Information: Name: Phone Number:	Preferred Method of Contact: ☐ Phone ☐ Email ☐ Mail ☐ Other: _____	
PCP Info (Name, Fax Number, Address):	Preferred Pharmacy: Is PCP Aware of Referral? ☐ Yes ☐ No	

Referral

Preferred Location in North York: ☐ East (of Yonge St.) ☐ West (of Yonge St.) ☐ No Preference	
Is Client Currently Enrolled in Chronic Disease Management Programs? (e.g. Lung Health Program, Cardiac Rehab) ☐ Yes (please list below) ☐ No	
Specialists/Programs Involved in Chronic Care Management:	
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.

Last updated: August 26, 2025