

REFERRAL FORM

PATIENT INFORMATION

Date: _____ (MM/DD/YYYY) Patient's Name: _____ Last name, First name Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> TS/TG Date of Birth: _____ (MM/DD/YYYY) Address: _____ Telephone: _____ Health Card Number: _____ Preferred Language: _____ CONSENT: Did the patient consent to the referral: <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Label
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CONTACT PERSON (IF DIFFERENT FROM PATIENT)

Name: _____ Phone: _____ Relationship to patient: _____

PRIMARY CARE PROVIDER

Name: _____ Phone: _____ Fax: _____

OTHER PROVIDERS INVOLVED IN CARE:

<p>REFERRAL SOURCE</p> <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> CCAC <input type="checkbox"/> CSS or MH & A <input type="checkbox"/> Other	<p>REFERRAL SOURCE CONTACT DETAILS (If Referrer is not the Primary Care Provider)</p> Name: _____ Organization: _____ Phone: _____ Fax: _____ Does the patient require CCAC services: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know REASON FOR THE REFERRAL TO HEALTH LINKS: (attach additional form if needed)
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<p>CLINICAL FACTORS (Check all that apply)</p> <input type="checkbox"/> Currently Hospitalized If yes, which hospital: _____ # of Hospital Admissions (12 mths) _____ # of ED visits (12 mths) _____ <input type="checkbox"/> Medical History Attached <input type="checkbox"/> Medications Attached <input type="checkbox"/> Medication Allergies Attached Chronic Morbidities: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<p>SOCIAL DETERMINANTS (Check all that apply)</p> <input type="checkbox"/> Lives Alone <input type="checkbox"/> Limited Social Network <input type="checkbox"/> Community Service Use <input type="checkbox"/> Financial Challenges <input type="checkbox"/> Transportation Challenges <input type="checkbox"/> Housing Challenges <input type="checkbox"/> Mobility Concerns <input type="checkbox"/> Home Bound
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Eligibility Guidelines

Health Links is a partnership of health care providers working together, to help patients with **medically and socially care complex needs**, get the care they require. A typical Health Links patient is someone that requires **intensive care coordination** to maintain stability.

Health Links aims to:

- help patients/families identify their health care goals and strategies to achieve them
- support linkages with primary care and other service providers
- improve the patient experience of those with complex care conditions
- reduce unnecessary emergency department visits and hospital admissions

The **clinical judgement of the Primary Care Provider** determines who is a Health Link patient. However, the following are guidelines to help identify those who will be best served by Health Links:

Must have 2 or more of the following:

- 4+ Chronic co-morbidities or multiple specialists (as per predicted Ministry guidelines)
- 4+ Chronic medications within the last 6 months
- 1+ acute inpatient stays within last 3 months (LACE score more than 10)
- Mental Health and Addiction condition
- 1 or more complex continuing care inpatient stays within last 6 months
- 1 or more inpatient rehabilitation stays within last 6 months
- 2 or more emergency department visits within last 6 months
- 1+ 911 health related call within last 3 months
- Primary care provider identifies patient not managing well
- Socially complex (reference Social Determinants of Health)

HealthLinks Mississauga Halton Boundaries

