Grand River Community Health Centre

Interprofessional Primary Care Team (IPCT) Referral Form for Providers

Provider information

Name _____ Date (mm/dd/yyyy) _____
Organization Name _____
Phone _____ Fax _____

Client information

Name _____ Date of birth (mm/dd/yyyy) _____
Address _____ City _____
Postal Code _____ Phone _____Email_____
Client pronouns are: ☐ She/her ☐ He/Him ☐ They/Them

Please check off the primary reason for the referral:

Group Programs:

- ☐ Heart health
- ☐ Pre-diabetes
- ☐ Caring for my COPD
- ☐ Mind Body Wellness Group
- ☐ Easy Fit (Gentle Exercise)
- ☐ New Moms

Individual support:

- ☐ Nutrition counselling – Nutrition education for clients across the human lifespan and goal setting to improve health
- ☐ Mental health counselling – Supporting individuals with developing positive coping strategies and achieving overall mental wellness
- ☐ Social prescribing – Assisting clients with connecting to non-clinical resources and services to improve social connection and well-being
- ☐ Well Baby Appointment with a registered nurse and a nurse practitioner.

Other reason for this referral: _____

_____

Please attach any relevant health information, including medical history, medications, and lab work.

Please Fax referral to 519-754-0757 Attn: IPCT Program