

Vaughan Location:
 9401 Jane St, Suite 206
 Vaughan, ON L6A 4H7
 Tel: 905-303-8490 ext. 4
 Fax: 905-303-4922

Keswick Location:
 716 The Queensway South
 Keswick, ON L4P 4C9
 Tel: 905-476-5621 ext. 2600
 Fax: 905-476-3008

[Complete or apply label here]

Client Name: _____
 DOB: _____
 OHIP#: _____ Version code: _____
 Gender: _____ Preferred Language: _____
 Address: _____
 Phone: _____

People Accessing Care Teams (PACT) Referral Form

Vaughan Community Health Centre gives priority for services to individuals from equity deserving communities, those living with complex medical and social needs, chronic medical conditions, and those facing barriers related to social determinants of health.

- ♦ The VCHC **will not** accept referrals for clients with open motor vehicle accident (MVA) or workplace injury claims.
- ♦ The VCHC **does not** provide physiotherapy services for clients with extended health benefits. Referred clients will be offered an appointment with the Case Manager to locate services in the community.

Reason for referral:

Mental Health Counselling (all ages) Please answer each question:

Reason for referral: _____

Specify any relevant mental health or developmental diagnosis: _____ None

Specify any risk issues: _____ None

The VCHC offers short term counselling, information, and referral to specialized services as needed. A Case Manager is available to assist with health system navigation. **Exclusion criteria:**

- | | | |
|--|--------------------------|---------------------------------|
| ♦ active substance use | ♦ eating disorders | ♦ psychoeducational assessments |
| ♦ actively suicidal or attempted suicide in the last six months | ♦ employment counselling | ♦ psychosis and mania |
| ♦ significant cognitive impairment, developmental or intellectual disability | ♦ fertility concerns | ♦ trauma as a primary concern |
| ♦ crime related, court orders or legal concerns | ♦ personality disorder | |

Social Prescribing (e.g., system navigation, group social programs, connection to services)

- Group programs related to: nutrition/healthy eating selfcare stress reduction dance/exercise classes
- Connection to community services (i.e., housing, settlement, legal, food access, financial or social assistance)
- Support with form completion Other: _____

Physiotherapy

Reason: _____ Time of onset: <1mth <3mth <6mth >1yr or persistent

Significant limitation of function (activities of daily living, work and/or leisure activity is affected)

Post Surgery: _____ Fracture: _____

Priority population (age 20-64 yrs or recent/risk of fall) Diagnostic Imaging results attached (if available)

Nutritional Counselling

Reason: _____

- GI Issues Food intolerance
- Prenatal, infant, toddler nutrition
- Weight, Cholesterol, Hypertension

(Please attach medication list and recent lab results)

Diabetes Education Program

Reason: _____

- Pre-Diabetes
- Type 2 Diabetes
- Insulin / GLP1 Start

(Please attach medication list and recent lab results)

Lung Health Program

- Respiratory assessment
- Consultation and education
- Smoking Cessation (STOP Program)
- Pulmonary Rehabilitation

(Please attach PFT results and/or proof of diagnosis)

[Complete or apply stamp to the right]

Referring provider name: _____

Signature: _____

Billing # (if applicable): _____

Date: ____/____/____
 DD / MM / YY