People Accessing Care Teams (PACT)
Vaughan Community Health Centre

☐ **Western York Region (WYR) - Vaughan Site**	☐ **Northern York Region (NYR) - Keswick Site**
9401 Jane St, Suite 106 and 206, Vaughan Phone: 905-303-8490 Fax: 905-303-4922	716 The Queensway South, Keswick Phone: 905-476-5621 Fax: 905-476-3008

Client Information	**Referring Provider Information**
Name, DOB, Health Card #, Version Code, Gender, Address, Phone #	Name, Billing #, Phone #, Fax #, Address **Signature**_____ **Date:** _____

Referred client has private health benefits: ☐ YES ☐ NO. Language: ☐ English ☐ French ☐ Other (please specify): _____

SERVICES REQUESTED – CHECK ALL THAT APPLIES. Note: incomplete referrals will not be processed

☐ Community Dietitian
Reason: _____
☐ GI issues ☐ Food intolerance
☐ Prenatal, Infant and Toddler Nutrition
☐ Weight, Cholesterol, Hypertension ☐Other_____

☐ Diabetes Education Program
Reason: _____
☐ Pre-Diabetes ☐ Type 2 Diabetes
☐ Insulin / GLP1 Start

☐ System Navigation and Case Management
☐ Health Navigation Services and Education
☐ Connection to community support, financial assistance, or social services
☐ Connection to settlement or legal services
☐ Information and Referral to: _____
☐ Information about VCHC or community group programs

☐ Physiotherapy (Non-MVA or WSIB).
Reason: _____

Time of onset: ☐ <1mth ☐ <3mth ☐ <6mth ☐ > 1 yr. or ☐ persistent

☐ Significant limitation of function (ADLs, work and/or leisure activity performance is affected)

☐ Post Sx _____ ☐ Fracture _____
☐ Priority population (clients aged 20-64 years or recent/risk of fall)

☐ Diagnostic imaging results if available (e.g., X Ray, MRI, ultrasound) and Medication list

☐ Mental Health *(Non-MVA or WSIB).*

Primary reason for referral:
☐ Caregiver Stress ☐ Loss/Grief
☐ Chronic Pain/Disease ☐ Self-esteem
☐ Eating Disorder ☐ Stress
☐ Family / Relationship ☐ Substance Abuse
☐ Anxiety ☐ Trauma
☐ Depression ☐ ADHD or Autism Spectrum
☐ Risk of harm. Specify: _____
☐ Mental Illness. Specify: _____
☐ Other: _____

☐ Chiropody – Reason: _____

☐ Skin pain and lesion (corns/callus/warts).
☐ Ingrown/involuted toenails ☐ Foot/toe pain
☐ Difficulty with activities of daily living _____
☐ Other: (please specify) _____

☐ Lung Health Program
☐ COPD Self-management education, Pulmonary Rehab
☐ Smoking Cessation (CAMH - STOP)
☐ Respiratory Consultation

☐ Spirometry
☐ Authorization to perform Pre and Post Spirometry testing
☐ Yes ☐ No
with ☐ Ventolin, as per medical directive

Medical History/ Medication list / Clinical Information (most recent bloodwork, diagnostic images)- or Please Attach

_____

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For more information on PACT services and for program updates please visit www.vaughanchc.com and subscribe.