Burlington Family Health Team (BFHT)
Physician Referral Form
(Complete pages 1 & 2)

Phone: 289-861-5611
Fax: 1-855-764-8360
www.burlingtonfht.com

Please select service(s) requested:

Physician Referral Required	Self-Referrals Accepted
☐ **Occupational Therapy** - Adults 18+ -Assessment re: functional, mobility, cognitive, home safety or balance/falls, rehabilitative support and self-management education.	☐ **Physiotherapy** - Adults 20+ NOT eligible for OHIP Physiotherapy and: -Have NO extended Health Benefits -Do NOT have an active WSIB or MVA claim -Do NOT have a personal injury claim or litigation
☐ **Registered Dietitian** -Adults 19+ -nutritional challenges/concerns related to illness or chronic disease. **Not eligible:** -Eating Disorders -Diabetes (refer to CFHT) -Pre/post bariatric surgery -Weight loss not related to illness	☐ **Psychotherapy** -Adults 18+ - mild to moderate anxiety and anxiety related disorders (OCD, Social phobia, panic disorder etc.), depression, ADHD, PTSD, Perinatal Wellness. -group & individual structured psychotherapy
☐ **Clinical Pharmacist** -Adults 25+ who are on 5 or more prescription medications **Not eligible:** -Patients who are acutely medically unstable	☐ **Community Remote Care Monitoring** -Adults 18+ -lives in Burlington -COPD & CHF - service provided by nurses and community paramedics.
☐ **Seniors Wellness Assessment** - Seniors 70 + - Frailty assessment, care plan, & services provided by a team of allied health clinicians	☐ **System Navigation** -Adults 18+ - One on one assessments & assistance to access community health & social services in the community.
☐ **Respiratory Therapy** -Adults 18+ **Service requested:** ☐ Spirometry ☐ Asthma and/or COPD Education ☐ Pulmonary Rehab *(requires spirometry & medical clearance):* ☐ needs spirometry ☐ spirometry results attached ☐ patient is cleared for supervised exercise	☐ **Footcare Services** - Adults 18+ with one or more of the following conditions: • a diagnosis of diabetes plus diabetic neuropathy, peripheral artery disease, chronic kidney disease, or a previous foot ulceration • Take blood thinners. • Have a foot condition that is impairing ability to walk. *(In Partnership with Acclaim Health)*

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Please complete required information:

Patient Information		
First Name:	Last Name:	
Health Card:	Phone:	DOB:
Address:		
Email:	Family Physician:	
Language Spoken:	Interpreter Required: ☐Yes ☐No	
Which language most comfortable with: ☐English ☐French		
Preferred Contact: ☐ Patient ☐ Other (*If other please include:)*		
Name:	Phone Number:	Relationship:
Referring Physician Name:		
Phone Number:	Fax Number:	
Reason for referral:		
Relevant Diagnosis:		
Please include any relevant documents and/or results.		

Fax completed referral to 1-855-764-8360