



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 |
|--|---|
| <input type="checkbox"/> Occupational Therapy - Adults 18+ - Assessment re: functional, mobility, cognitive, home safety or balance/falls, rehabilitative support and self-management education. | <input type="checkbox"/> 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 |
| <input type="checkbox"/> Seniors Wellness Assessment - Seniors 70 + - Frailty assessment, care plan, & services provided by a team of allied health clinicians | <input type="checkbox"/> System Navigation - Adults 18+ - One on one assessments & assistance to access community health & social services in the community. |
| <input type="checkbox"/> Clinical Pharmacist - Adults 25+ who are on 5 or more prescription medications Not eligible: - Patients who are acutely medically unstable | <input type="checkbox"/> Community Remote Care Monitoring - Adults 18+ - lives in Burlington - COPD & CHF - service provided by nurses and community paramedics. |
| <input type="checkbox"/> 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 | <input type="checkbox"/> Footcare Services (In Partnership with Acclaim Health) - Adults 18+ with one or more of the following: <ul style="list-style-type: none"> • 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. |
| <input type="checkbox"/> Respiratory Therapy - Adults 18+ Service requested: <input type="checkbox"/> Spirometry <input type="checkbox"/> Asthma and/or COPD Education <input type="checkbox"/> Pulmonary Rehab (<u>requires spirometry & medical clearance</u>): <input type="checkbox"/> needs spirometry <input type="checkbox"/> spirometry results attached <input type="checkbox"/> patient is cleared for supervised exercise | Psychotherapy – please note, all mental health referrals are now submitted through one-Link. Referral form can be found here: https://www.burlingtonfht.com/for-physicians#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 |



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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: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Which language most comfortable with: <input type="checkbox"/> English <input type="checkbox"/> French | | |
| Preferred Contact: <input type="checkbox"/> Patient <input type="checkbox"/> Other (<i>If other please include</i>) | | |
| 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