MyCareSTEPS

Care Coordination Patient Referral Form

Submit via:
Fax: 647-492-0401
Email: referrals@mycaresteps.ca

Patient Information

Full Name: Date of Birth (YYYY-MM-DD):

Phone Number: Email (optional):

Alternate Caregiver Contact

Name: Relationship to Patient:

Phone Number:

Referring Provider Information

Referring Provider Name: Clinic / Organization:

Phone Number: Email Address:

Date of Referral:

Clinical Information

Reason for Referral (Primary Concern):

Relevant Medical History:

Supporting Documentation (Check all that apply)

☐ Recent clinical notes ☐ Consultation reports ☐ Diagnostic test results ☐ Medication list ☐ Other:

Consent & Acknowledgement

Has the patient consented to this referral? ☐ Yes ☐ No

Privacy Statement

☐ I understand that the information collected will be used to coordinate care and handled in accordance with applicable privacy legislation.

Program Partners

serefin HEALTH PHARMASAVE Rocket Doctor

This project is a partnership between Serefin Health, Pharmasave, and Rocket Doctor.

www.mycaresteps.ca