





HPCN Central Programs Referral Form

The Highland Primary Care Network (HPCN) offers a variety of programs centrally to support physicians and patients with their mental, social, and physical health. Please refer to the HPCN Program Overview document to help your decision making on which program is relevant for the patient. **Please note, incomplete forms will be returned.**

DOB: Referred By: Address: Phone: Family Physician: Phone:	Patient Name:	Referral Date:
Address: Phone: Family Physician: Parent/Guardian Name (if applicable): Parent/Guardian Name (if applicable): Phone: Referral Options: Allied Health Team (please choose provider): Ambulatory Blood Pressure (24 hr) Health Improvement Program (HIP) Mental Health Triage Provide details specific to reason for referral: Include applicable clinical information to assist with assessment: Current medications Diagnostic Imaging, Lab work Diagnostic Imaging, Lab work Clinical notes Is the patient aware of this referral?	PHN:	
Phone: Family Physician: Parent/Guardian Name (if applicable): Phone: Referral Options: Allied Health Team (please choose provider): Ambulatory Blood Pressure (24 hr) Health Improvement Program (HIP) Mental Health Triage Provide details specific to reason for referral: Include applicable clinical information to assist with assessment: Current medications Diagnostic Imaging, Lab work Diagnostic Imaging, Lab work Clinical notes Is the patient aware of this referral?	DOB:	Referred By:
Parent/Guardian Name (if applicable): Parent/Guardian Name (if applicable): Phone: Referral Options: 7to7teen	Address:	
Parent/Guardian Name (if applicable): Referral Options: 7to7teen	Phone:	
Referral Options: 7to7teen	Family Physician:	
☐ 7to7teen ☐ Allied Health Team (please choose provider): ☐ D ☐ Ambulatory Blood Pressure (24 hr) ☐ Chronic Pain ☐ K ☐ Health Improvement Program (HIP) ☐ Mental Health Triage Provide details specific to reason for referral: ☐ Include applicable clinical information to assist with assessment: ☐ ☐ Current medications ☐ Allergies ☐ Diagnostic Imaging, Lab work ☐ Screening i.e. PHQ9, GAD7 ☐ List of medical conditions ☐ Clinical notes Is the patient aware of this referral? ☐ Yes ☐ No	Parent/Guardian Name (if applicable):	Phone:
□ Ambulatory Blood Pressure (24 hr) □ Chronic Pain □ K □ Health Improvement Program (HIP) □ Mental Health Triage Provide details specific to reason for referral: □ Include applicable clinical information to assist with assessment: □ Current medications □ Allergies □ Diagnostic Imaging, Lab work □ Screening i.e. PHQ9, GAD7 □ List of medical conditions □ Clinical notes Is the patient aware of this referral? □ Yes □ No	Referral Options:	
☐ Health Improvement Program (HIP) ☐ Mental Health Triage Provide details specific to reason for referral: ☐ Include applicable clinical information to assist with assessment: ☐ Current medications ☐ Allergies ☐ Diagnostic Imaging, Lab work ☐ Screening i.e. PHQ9, GAD7 ☐ List of medical conditions ☐ Clinical notes Is the patient aware of this referral? ☐ Yes ☐ No	☐ 7to7teen	☐ Allied Health Team (please choose provider): ☐ Dietitian
Provide details specific to reason for referral:	\square Ambulatory Blood Pressure (24 hr)	☐ Chronic Pain ☐ Kinesiologis
Include applicable clinical information to assist with assessment: Current medications Diagnostic Imaging, Lab work Screening i.e. PHQ9, GAD7 List of medical conditions Screening i.e. PHQ9, GAD7 Clinical notes	☐ Health Improvement Program (HIP)	☐ Mental Health Triage
 □ Current medications □ Diagnostic Imaging, Lab work □ Screening i.e. PHQ9, GAD7 □ List of medical conditions □ Clinical notes Is the patient aware of this referral? □ Yes □ No 	Provide details specific to reason for referra	al:
 □ Diagnostic Imaging, Lab work □ Screening i.e. PHQ9, GAD7 □ List of medical conditions □ Clinical notes Is the patient aware of this referral? □ Yes □ No 	Include applicable clinical information to ass	sist with assessment:
☐ List of medical conditions ☐ Clinical notes Is the patient aware of this referral? ☐ Yes ☐ No	☐ Current medications	☐ Allergies
Is the patient aware of this referral? \Box Yes \Box No	☐ Diagnostic Imaging, Lab work	☐ Screening i.e. PHQ9, GAD7
·	\square List of medical conditions	☐ Clinical notes
Is the patient seeing other healthcare providers? Yes No If yes, please specify:	Is the patient aware of this referral?	☐ Yes ☐ No
	Is the patient seeing other healthcare provi	iders? ☐ Yes ☐ No If yes, please specify:
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