Bridgepoint Hospital
14 St. Matthews Road
Toronto, ON M4M 2B5
Tel: 416-461-8252

BRIDGEPOINT active healthcare

Complexity Clinic Referral Form

PATIENT INFORMATION:

Name: _____ Address: _____
Daytime Tel #: _____ Health Card: _____
Family Doctor: _____ Date of Birth: _____
Is an interpreter required? ❒Yes ❒No (If yes, specify language)_____
Who to contact with appointment information? *(this is who we will contact for the appointment)*
Name:_____ Phone #:_____

❒ **CARE Clinic**
Dr. L. Nickell, Dr. R. Upshur, Dr. R. Adler

❒ **Polypharmacy Clinic**
Dr. R. Upshur with pharmacist

Specialist MD Clinics:
- ❒ Endocrinology – Dr. D. Reiss
- ❒ General Internal Medicine – Dr. D. Reiss
- ❒ Geriatric Psychiatry – Dr. M. Lachmann
- ❒ Physiatry – Dr. C. Fortin

SPECIFIC QUESTIONS TO BE ADDRESSED:

REFERRING PHYSICIAN INFORMATION:

Name: _____ Physician Billing #: _____
Signature: _____ Date: _____
Tel: _____ Fax: _____
Email: _____ Address: _____
Catchment Area: ❒ Don Valley Greenwood HealthLink ❒ East Toronto HealthLink
(N.B. Either patient or referring primary care provider must be located in the catchment area)

Please attach: recent lab data/neurological imaging, relevant specialist referrals, current medication list, allergies

Please FAX referral form to 416-461-2089

Trial version 1.0

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SUPPLEMENTARY PATIENT INFORMATION

HOMEBOUND?
❒ Yes ❒ No

ON CCAC SERVICE?
❒ Yes ❒ No
What is being provided?

OTHER CARE PROVIDERS INVOLVED:

SUPPORTS IN PLACE:

CAPACITY ISSUES:
(if possible specific and outline concern)

Personal Care:

Application to LTC:

Finances:

PATIENT/CLIENT KEY GOALS:

FAMILY GOALS:

DO YOU HAVE CONCERNS ABOUT MEDICATIONS?
❒ Yes (specify: _____)
❒ No

POWER OF ATTORNEY FOR PERSONAL CARE (IF RELEVANT AND KNOWN):
NAME:_____
CONTACT INFO:_____

DOES THE PATIENT HAVE AN ADVANCED CARE PLAN?
❒ Yes ❒ No