

## Interprofessional Primary Care Team (IPCT) Referral Form for Providers

Provider information					
Name	ame		Date (mm/dd/yyyy)		
			Fax		
Client	information				
Name			Date of birth (mm/dd/yyyy)		
			City		
Postal	Code	Phone		Email	
Client	pronouns are:	She/her	🗌 He/Him	They/Them	
Please check off the primary reason for the referral:					
Group Programs:					
	Heart health			Mind Body Wellness Group	
	Pre-diabetes			Easy Fit (Gentle Exercise)	
	Caring for my COPD			New Moms	
Indivi	dual support:				
	<ul> <li>Nutrition counselling – Nutrition education for clients across the human lifespan and goal setting to improve health</li> </ul>				
	improve social connection and well-being				
	<ul> <li>Well Baby Appointment with a registered nurse and a nurse practitioner.</li> </ul>				
Other reason for this referral:					
Please attach any relevant health information, including medical history, medications, and lab work.					

Please Fax referral to 519-754-0757 Attn: IPCT Program