Carefirst Preventive Care Referral Form
Carefirst Seniors and Community Services Association
300 Silver Star Blvd Scarborough ON, M1V 0G2
Phone: 437-772-3415 Fax: 437-900-0023

SERVICE(S) REQUESTED: ☐ Preventive Care

REFERRAL TO OTHER CAREFIRST SERVICE(S): ☐ Refer to other Carefirst programs/services as appropriate

URGENCY LEVEL: ☐ Urgent ☐ Routine

REASON(S) FOR REFERRAL (SELECT ALL THAT APPLY):

☐ Cancer screening support (OBSP, cervical/HPV, FIT, lung)

☐ Diabetes prevention/ screening (e.g. CANRISK)

☐ Behaviour change coaching (e.g. healthy eating, exercise)

☐ Alcohol harm reduction

☐ Smoking cessation support

☐ Social determinants of health support

☐ Needs help accessing primary care/unattached to PCP

☐ Chronic disease risk reduction ☐ Other: _____

PATIENT INFORMATION:

FIRST NAME: _____ **LAST NAME:** _____

Date of Birth (D/M/Y): _____ **Gender:** ☐ Male ☐ Female ☐ Other: _____

Preferred Language: ☐ English ☐ Other: _____ **Interpreter required?** ☐ Yes ☐ No

Address: _____**City:** _____

Postal Code: _____ **Health Card Number:** _____

Phone (mobile): _____ **(Alternate):** _____

Email address: _____ **Preferred Contact Method:** ☐ Phone ☐ Email ☐ Either

Patient consents to SMS/email communication (e.g. appointment reminders): ☐ Yes ☐ No

Primary Contact Person (if different from patient): _____

Optional but helpful. Please attach all relevant supporting documents including patient profile, medication list, consultations, x-ray, CT, blood work , etc.

_____ _____

Signature *Date*