South Island & Victoria Primary Care Network Priority Referral Form

New Patient Priority Referral form for unattached patients- Fax to 778-698-4569

- Use this form **ONLY** to flag patients in your care that need high priority attachment to a primary care provider.
- Please fill out all contact information including BC PHN **(all other provinces will not be accepted)**
- This form does NOT guarantee attachment.
- Patients on Health connect Registry will not be provided care until a practitioner becomes available.
- **All information on form needs to mirror BC Care Card information.**
- Forms without consent provided cannot be processed.

Patient Name Contact Information (or Label)

Name:_____ **Date of Birth:**_____
PHN:_____ **HCR ID#:**_____
Phone #:_____ **Email:**_____
Address:_____

Referrer's Name/Occupation:_____
Referrer's Contact Information:_____

Main reason that patient requires urgent attachment to a provider

(List specific reason for referral below)

Referring Maternity ☐ **Referring Primary Care** ☐

Check all known factors

Medical Complexity (M)	Mental Health Substance Use (S)	Psychosocial (P)	Pediatrics	Resource Utilization/Other
☐ CHF/COPD/DM/HTN ☐ Chronic Pain ☐ Chronic Wound ☐ Chronic Opioid or Benzodiazepine ☐ Active Cancer ☐ Non- Malignancy Progressive Condition ☐ Frail Elderly ☐ Palliative Care/End of Life - Less 6months ☐ Other (specify)	☐ Chronic Mood Disorder ☐ Chronic Anxiety Disorder ☐ Personality Disorder ☐ Psychotic Disorder ☐ Substance use Disorder ☐ Dementia with Disruptive Behaviour ☐ Other (specify)	☐ Low Socio-Economic Status ☐ Parent/Child who is at risk ☐ Unemployed or Disability ☐ Unstable Housing ☐ Mobility Issues ☐ Other (specify) **Perinatal** **Pregnant >** **Due Date:**_____ ☐ Trying to Conceive/ Infertility ☐ Newborn Dyad ☐ Postpartum	☐ Child with significant Chronic condition >2 Body systems ☐ Progressive condition associated with deteriorating health ☐ Malignancies that Affect life function ☐ Other (specify)	**Past 12 Months** ☐ >5 ED Visits ☐ >5 Walk-in visits ☐ >2 Admissions ☐ LOS>8.1 days in Admissions ☐ Other (specify) **Priority Population** ☐ LGBTQIA2S+ ☐ Self identifies as Indigenous

Please list other information:

Submitting this form, the referring professional attests they have the patient's permission and have obtained their consent to share information with Primary Care Network and Division of Family Practice using this information for the purpose of attachment to a provider.