



# High-Complexity Care Team

## New Patient Referral Form

Fax to 778-265-3169

- Use this form only for patients who you feel meet the criteria for HCCT
- This form does NOT guarantee attachment
- The referring clinician confirms they have obtained the patient's consent to be referred
- This referral grants HCCT permission to update the patient's status with the Health Connect Registry

### Essential: Patient Contact Information and Demographics:

Patient's Name: _____	PHN: _____
Patient's DOB: _____	Patient Email: _____
Patient's Phone: _____	Patient's Address: _____

### Essential: Referring Clinician Contact

Referring Clinician Name and Occupation: _____
Referring Clinician Contact Information: _____

**Without the above information, referral will be returned**

- New Unattached Patient     Consult (for existing Primary Care Provider)
- FND Consult with Consideration of FND Group (note that not all patients are group candidates)

**NOTE: Referral doesn't guarantee attachment. You may be contacted for clarification.**

Medical Complexity	Mental Health/Substance Use	Psychosocial	Pediatric	Resource Utilization
<input type="checkbox"/> Chronic GI Disorder <input type="checkbox"/> <b>Uncontrolled</b> CHF <input type="checkbox"/> <b>Uncontrolled</b> COPD <input type="checkbox"/> <b>Uncontrolled</b> Diabetes <input type="checkbox"/> Chronic Opioids or Benzos <input type="checkbox"/> Chronic Wound <input type="checkbox"/> Active Malignancy <input type="checkbox"/> CHSA Frailty score >6 <input type="checkbox"/> Other (specify)	<input type="checkbox"/> Chronic Mood Disorder <input type="checkbox"/> Chronic Anxiety Disorder <input type="checkbox"/> Psychotic Disorder <input type="checkbox"/> Personality Disorder <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> Dementia with disruptive behaviour <input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Low Socio-Economic Status <input type="checkbox"/> Parent/Child who is also at risk <input type="checkbox"/> Unemployed or Disability <input type="checkbox"/> Unstable Housing <input type="checkbox"/> Mobility Issues <input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Child with Significant Chronic Condition >2 body systems <input type="checkbox"/> Progressive condition associated with deteriorating health <input type="checkbox"/> Malignancies that affect life function <input type="checkbox"/> Other (specify)	<b>In The Past 12 months</b> <input type="checkbox"/> > 5 ED Visits <input type="checkbox"/> >5 Walk-in/UPCC visits <input type="checkbox"/> >2 Admissions <input type="checkbox"/> LOS >8.1 days in admissions <input type="checkbox"/> Other (Specify)

**Clinician's Comments: Give us a sense of why you feel the patient specifically requires HCCT**

<b>Total Score =</b>	<b>(scores less than 10 unlikely to be attached)</b>
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In submitting this form, the referring professional attests they have the patient's permission and have obtained their consent to share information with the HCCT and to update the patients HCR Status

**HCCT – #120-27 Helmcken Rd Victoria BC V8Z5G5 – Phone 250-940-5692 – Fax: 778-265-3169**