CHANCES Family Health Clinic
77 Upper Prince St. Charlottetown, PE. C1A 4S6
Tel: (902) 367-3218 Fax: (902) 367-3313
email: chances@chancesfamily.ca web-site: www.chancesfamily.ca

Unaffiliated Client Referral

Last name:_____ First Name:_____

DOB (yyyy/mm/dd):_____

Health Card #:_____ Expiry date:_____

Address: _____ Phone number (h):_____

City:_____ (w): _____

Postal Code:_____ (c):_____

Who should be contacted first, if not the client:

Name:_____ Relationship to client:_____ Phone number:_____

Can we leave a message (may contain medical information)? Yes ☐ No ☐

Referral Source: **Public Health Nursing** ☐ **Pediatric Clinic** ☐ **Other** ☐		
Referral Date:	**Contact Name:**	**Phone number:**
Reason for referral:		

Please complete the following sections if applicable:

Birth and Neonatal History:

Gestational Age:_____ Weight:_____ Length:_____ HC:_____ Apgar (score):_____

Comments:_____

_____

Last Examination in Office:

Date: _____ Wt:_____ Ht:_____ BMI:_____ Growth Charts enclosed ☐

Comments:_____

_____

_____

MEDICAL/SURGICAL HISTORY: Significant illnesses

No.	Problem	Date(s)	Subspecialist consulted	Treatment/Outcome
1.				
2.				
3.				

Current Medications:_____

_____

_____

Current Consultations/Investigations:_____

_____

_____

Known or Suspected Allergies:_____

_____

For CHANCES Family Health Clinic use only

_____

Referral received (date):_____ Reviewed by (initial):_____

Disposition of Referral	
Urgent (ASAP)	
Semi-urgent (within 2 weeks)	
Routine (next available apt.)	

Please note: ***Once completed please send by fax; mail; or e:mail to the contact information outlined at the top of the form. This document is also available for download from the CHANCES web-site under the resources section, specifically for use by Public Health Nursing and the Pediatric Clinic.***