Hôpital de Montréal pour enfants
Centre universitaire de santé McGill

Montreal Children's Hospital
McGill University Health Centre

Intermediate Complexity Coordination and Navigation (I-CCAN) Service
Physician Referral Form

1- Practice Information

Referring Physician: _____	Primary Care Physician: _____ (If different from referring physician)
Fax: Phone:	Fax: Phone:

2- Patient Demographics

Patient Name: _____ Date of birth:_____ Gender: M ☐ F ☐

Montreal Children's Hospital Number (if available): _____

Parent /Caregivers Name: _____ Home Phone: _____

Alt Phone: _____ Address: _____

City:_____ Province: _____

Postal Code: _____ Language of correspondence: _____

Translator needed? : Y ☐ N ☐ _____ Language: _____

Can we leave a message at home/alt. phone? Y ☐ N ☐

Family doctors or pediatrician : _____

Consent obtained from parent / caregiver for referral? **(MANDATORY)** ☐

3- Medical Specialty Teams or Services Involved in the Care of the Child (Doctors, physiotherapy, occupational therapy, dietician, speech language pathology, social work, nursing, etc.)	**Location** (Montreal Children's Hospital, CHU Sainte-Justine, rehabilitation centre, community clinic, etc.)

4- Specify the Care Coordination and Navigation Needs of the Child (Needs help scheduling multiple medical visits and/or imaging/tests and/or therapies/procedures, Needs help to facilitate transfer of information between health professionals and/or across health/care facilities, etc.)

4-Additional Information

☐ I acknowledge that this referral does not guarantee automatic acceptance into the I-CCAN

Referent 's signature: _____ Date: _____