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 Family Referral Form

1- Patient Demographics

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

MCH card number (if available): _____ Home Phone: _____

Parent /Caregivers Name: _____ Phone (other): _____

Address: _____ Language of correspondence: _____

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

Province: _____ Family doctor or pediatrician : _____

Postal Code: _____ Diagnosis: _____

Email address: _____

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

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

3- Please Specify the Care Coordination and Navigation Needs of Your Child

(Help scheduling multiple medical visits and/or imaging/tests and/or therapies/procedures, 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

Parent signature: _____ Date: _____