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 Request for consultation by health care professional

1- Practice Information

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

2- 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: _____ Diagnosis: _____

Postal Code: _____ Parent's email address: _____

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

Consent obtained from parent / caregiver for I-CCAN 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: _____