northern health
the northern way of caring

All Sites and Facilities

HIV/HCV Specialized Support Team Consultation Request Referral Form

Patient name: _____

Address: _____

Phone #: _____

Email: _____

PATIENT LABEL

Primary care provider, specialists, community agencies, communicable disease nurse, detox staff, acute care staff or the person themselves may make a request for consultation.

Name: _____ **DOB:** _____ **PHN:** _____

Best way to contact person: ☐ Phone ☐ Address ☐ Email ☐ Text ☐ Other: _____

Person would prefer consultation by: ☐ In-person ☐ Phone ☐ Telehealth videoconference

Referred by: _____ Phone #: _____ Email: _____

Community pharmacy: _____

Other physicians/specialists/specialized services: _____

Does this person have a primary care provider (family doctor, nurse practitioner)?

☐ Yes → Name: _____

☐ No

Type of consultation required:

☐ **Nurse practitioner**: Opioid agonist treatment, provision of temporary primary care, and linkages to permanent primary care homes

☐ **Pharmacist**: Optimizing and accessing medications, side effect management, drug interactions/information, PrEP

☐ **Dietician**: Optimizing nutrition, weight gain or loss, food safety, monthly nutritional supplement

☐ **Social worker**: Optimizing social determinants of health, advocacy, community resources

Reason for referral (note any challenges/questions/goals)

_____

_____

_____

_____

_____

Health issues/medical problem list

☐ Addictions	☐ Diabetes	☐ HIV	☐ Osteoporosis
☐ Cancer	☐ Dyslipidemia	☐ Hypertension	☐ Renal dysfunction
☐ Cardiovascular disease	☐ Hepatitis B	☐ Mental health condition	☐ TB (active or latent)
☐ COPD	☐ Hepatitis C	☐ Neurological disorder	☐ Other: _____

Please send completed form to SST confidential fax number 1-844-440-4454 or phone toll free 1-888-645-6495.
Please attach any relevant investigations and/or consults.

Administrative use

Date received: _____ Date primary care provider notified of consultation request: _____