CLEAR

WINDSOR TEAM CARE CENTRE (WTCC) REFERRAL FORM

Complete first page of referral form only

2475 McDougall St, Suite 150, Windsor, ON N8X 3N9
Phone: 519-250-5524 Fax: 519-250-3894
www.windsortcc.ca

Our Mandate: Provide multidisciplinary care in collaboration with Primary Care Providers in Windsor-Essex for patients with chronic conditions, mild to moderate mental health, and addictions through team-based allied health.

Patient Information			Date of Referral:		
Name: (First, Last)			Address:		
Date of Birth:			OHIP #:		
Phone: (H) (M)			Email:		
Language:	English French Other:	Sex:	Male Female Decline	Gender Identity:	
Patient provided verbal consent to participate in Team Care? Yes No			Patient provided verbal consent for Team Care to leave a confidential voicemail? Yes No		

Please review service descriptions, inclusion, and exclusion criteria on page #2 of sample form or at www.windsortcc.ca. Individuals should exhaust all third-party healthcare insurance prior to referral.

Services Requested *(Service descriptions and criteria are explained on page #2 of sample referral form)*

Please identify requested services by checking the boxes below for WTCC programs.

- Addiction Counselling
- Dietitian/Nutrition Counselling
- Foot Care
- Lung Health (including Pre/Post Spirometry)
- Memory Clinic (as of October 2023)
- Mental Health Care
- Musculoskeletal (MSK) Health
- Oral Health Education Program
- Pharmacy/Medication Reconciliation

Reason for Referral/Notes:

Requested Documentation/Attachments

- Patient Medical Profile *(all referrals)*
- Recent Imaging *(MSK Health)* ☐ N/A
- Primary psychiatric diagnosis & co-morbidities, including addictions & pain disorders *(Mental Health Care)* ☐ N/A
- Psychiatry consultation notes *(Mental Health Care)* ☐ N/A

Provider Stamp: