BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

Affix patient label here

Complex Chronic Diseases Program (CCDP) Referral

PHONE: (604) 875-2061 FAX: (604) 875-3738

Referral Date: _____

We do not accept re-referrals. If the patient has participated in the CCDP previously, please call 604-875-2061 or Toll-Free (BC): 1-888-300-3088 ext. 2061 for a provider to provider consult.

CCDP's model of care takes an **education-first approach**. Patients can access group education sessions and self-management support from nurses, social workers, physiotherapists, occupational therapists, and dieticians. **As needed,** staff will connect patients with physician specialists.

A: REFERRING CLINICIAN

Name: _____ MSP# _____ Specialty: _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____ Email: _____

PRIMARY CARE PROVIDER (if different from referring clinician): _____ MSP# _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____ Email: _____

B: PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle initial: _____

PHN: _____ DOB (dd/mmm/yyyy): ____ / _____ / _____ Pronouns: ❑ He/Him

Address: _____ City/Town: _____ ❑ She/Her

Postal Code: _____ Email: _____ ❑ They/Them

Phone: (____) _____ - _____ Is an interpreter required? ❑ No ❑ Yes, language: _____

C: CLINICAL INFORMATION

REQUIRED: Complete all fields

1. Is the patient **19 years or older**, and a resident of **British Columbia with MSP**? *If not, please refer once patient is 19 years old*	Yes❑
2. Does patient have **CONFIRMED** diagnosis of **ME/CFS?** **CONFIRMED** diagnosis of **Fibromyalgia?** **CONFIRMED** diagnosis of **Symptoms attributed to Lyme disease**?	Yes❑ No, suspected❑ Yes❑ No, suspected❑ Yes❑ No, suspected❑
3. Date of **symptom onset**? mmm/yyyy	: _____
4. Date of **diagnosis** & **diagnosing physician** (if applicable)? dd/mmm/yyyy Diagnosed by	: _____ : _____
5. Does the patient meet any **urgent triage criteria:** • Is the patient between 19 to 25 years of age? • Is the patient unable to leave home? • Was symptom onset less than 3 years ago?	No❑ Yes❑ No❑ Yes❑ No❑ Yes❑
6. Have you attached: **Consults within the last 2 years** related to the investigation and management of the patient, including differential diagnosis investigations to rule out other conditions explaining the symptoms, a history, and physical examination	Yes❑
7. Have you informed the patient that this is a multidisciplinary clinic that supports recovery through **group self-management** activities? • Patients must be willing to engage in self-management activities and group rehabilitation classes online	Yes❑

Fax completed referral and required documents to: 604-875-3738

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FOR BC WOMEN'S OFFICE USE ONLY:

- ❑ Referring office has been notified
- ❑ Letter has been completed Date:
- ❑ Patient has been notified Date:
- ❑ Cerner Date:

❑ Wait list: ____/____/____ Initial: _____
DD / MM / YEAR

Reviewed by: _____

Date: _____