Integrated Chronic Care Service Referral

Surname First Name

Permanent Address City Prov.

Postal Code Cell Phone Home Phone

Date of Birth Sex Gender

HCN# Expiry Date

Email:_____

The Integrated Chronic Care Service (ICCS) is an interdisciplinary team clinic that provides ***short term*** support for individuals diagnosed or presenting with symptoms of Chronic Fatigue Syndrome/ Myalgic Encephalomyelitis (ME), Fibromyalgia, Multiple Chemical Sensitivity/ Environmental Illnesses and Post COVID. We do not provide primary care. We are a not a chronic pain clinic. Please fill in all the sections below.

☐ New Patient referral ☐ Re-referral Approx. date last seen at ICCS:_____

Is this referral related to Post-COVID? ☐ No ☐ Yes
If Yes, COVID can exacerbate pre-existing health conditions. Please ensure any such conditions are stabilized prior to referral to ICCS.

REFERRING PRIMARY CARE PROVIDER (Please print clearly)

I am the Primary Care Provider ☐ Yes ☐ No: _____

☐ The individual **does not** have a primary care provider.

Name: _____

Phone: _____ Fax: _____

Address: _____

_____

_____

PRIMARY REASON FOR REFERRAL

Confirmed or suspected diagnosis of: ☐ Chronic Fatigue Syndrome/ME ☐ Post COVID

☐ Fibromyalgia ☐ Multiple Chemical Sensitivity/Environmental Illnesses

History of illness & work up completed: _____

_____

_____

_____

_____

Presenting complaints (check all that apply):

- ☐ Persistent fatigue and/or exertional intolerance
- ☐ Dermatitis
- ☐ Nonrestorative Sleep
- ☐ Persistent Cough
- ☐ Shortness of Breath
- ☐ Muscle Pain
- ☐ Weakness
- ☐ Generalized pain
- ☐ Gastrointestinal upset
- ☐ Airway/respiratory irritation
- ☐ Orthostatic intolerance
- ☐ Cognitive Difficulty ("Brain Fog")
- ☐ Depression/ Anxiety
- ☐ Other Mental Health Conditions

Other: _____

_____

_____

Specialties Consulted: Please attach relevant consults.

- ☐ Neurology
- ☐ Gastroenterology
- ☐ Rheumatology
- ☐ Allergy
- ☐ Dermatology
- ☐ Mental Health Services
- ☐ Other: _____

Other Health Conditions: _____

_____

_____

☐ I agree to provide ongoing primary care and appropriate follow up while the patient is engaged with ICCS.

☐ I am aware that treatment and recommendations will be provided. I will support the management of their chronic health condition following discharge from ICCS.

☐ I have included only relevant labs, diagnostic imaging, and consultations.

Incomplete referrals will be returned to sender.

Please forward this referral and other relevant documentation to:

Integrated Chronic Care Service

3064 Highway 2

Fall River, NS, Canada, B2T 1J5

Phone: (902) 860-3066

Fax: **1-833-875-0143**