Bar Code
(For ICCS use only)

Surname ________ First Name ________

Permanent Address ________

Postal Code ________ Cell Phone ________ Home Phone ________ Work Phone ________

Date of Birth ________ Age ________

HCN# ________ Expiry Date ________

INTEGRATED CHRONIC CARE SERVICE REFERRAL

The Integrated Chronic Care Service (ICCS) is an interdisciplinary clinic that provides comprehensive assessment, treatment, and care planning for individuals with symptoms consistent with Chronic Fatigue Syndrome, Fibromyalgia, Multiple Chemical Sensitivity as well as other complex chronic conditions and multi-morbidities. We offer a holistic, whole person approach guided by the ***patient's self-identified functional goals and readiness to make lifestyle changes.***

We are a consultation-based service and do not provide primary care. ICCS guided treatment is typically 6-9 months, with ongoing collaboration with the referring Physician or Nurse Practitioner.

Date of referral: ______/______/______
DD MM YY

Interpreter required ☐ No ☐ Yes
Language: ________________________

Reason for Referral: ☐ New Patient Referral ☐ Re-referral: Approx. last date seen at ICCS __________

____
____
____
____
____

Other relevant diagnosis and health concerns (mental health, diabetes, cardiac etc):

____
____

Is the patient sensitive to chemicals? ☐ No ☐ Yes ☐ Unknown

Please check the Patient's work status:

☐ Working ☐ Working modified hours or duties ☐ Off Work ☐ Unemployed
☐ Other: ____

Please check if the Patient is currently receiving any of the following:

☐ Workers Compensation ☐ CPP disability ☐ Long term disability ☐ Short term disability
☐ Income assistance ☐ Other: ____

Are any of the above being considered or pending? ☐ No ☐ Yes: ________________________

Designation Code
(For ICCS use only)

nova scotia health authority

For ICCS use only

Please include work-up for referred health issues:

☐ Consultations ☐ Lab Reports ☐ Diagnostic Imaging ☐ Sleep Study ☐ None available (please provide a brief history)

____

____

____

____

____

Referring Primary Care Provider (FP/NP): ________________________________

Address: ____

Phone: ______________________ FAX: ______________________

☐ I am the Primary Care Provider
☐ I am not the Primary Care Provider

______________________________ ______________________
Referring Provider Signature Date

Please forward this referral form and other relevant documents (lab tests, consultation reports etc.) by mail or fax to:

Integrated Chronic Care Service
3064 Highway 2
Fall River, NS, Canada, B2T 1J5
Phone: (902) 860-0057
Fax: (902) 860-2046

FOR ICCS USE ONLY:

Category: __________ Reviewed by: ______________________ Date: ______________

Orientation Session: ☐ Reg. ☐ FF ☐ TC ☐ 1:1 *phone* *in-person* ______________

Medical Intake: ☐ Dr. Fox ☐ Dr. Goth ☐ Heather Livingston, NP

Additional Notes: ____