BLACK CREEK
COMMUNITY HEALTH CENTRE

People Accessing Care Teams - PACT

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Patient Information	Referring Physician
Name, Health Card #, DOB, Version code, Gender, Address, Phone #	Name, Billing #, Phone #, Fax #, Address Signature_____ Date: _____

Referral type (For Internal use only)

☐ Medical/physical ☐ Mental health and/or addictions ☐ Social

Services requested (Please check all that apply)

☐ Chiropody/Assessment & screening	☐ Registered dietitian	☐ Harm Reduction
☐ Foot Care	☐ Registered kineosologist (Exercise)	☐ Social worker/Therapist
☐ COPD education & Smoking cessation	☐ Retinal screening (Tele-ophthalmology)	
☐ Diabetes education & management (Please attached the DEP form)	☐ Sexual health clinic (Walk -in)	☐ Community support & social services
☐ International Board Certified lactation consultant		☐ System navigator
☐ Physiotherapy (Non MVA)		

All our services are provided in English and French

Medical history

Medication list

Other clinical Information/ Most recent bloodwork