Champlain CCAC CASC
Community Care Access Centre
Centre d'accès aux soins communautaires de Champlain

Head Office
4200 Labelle Street
Suite 100
Ottawa ON K1J 1J8
Tel: 613-745-5525
1-800-538-0520

Siège social
4200, rue Labelle
Bureau 100
Ottawa (ON) K1J 1J8
Tél: 613-745-5525
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CCAC Referral

For Community Referrals - Fax Form to Champlain CCAC: 613-745-6984 or 1-855-450-8569

Estimated Date of Discharge (EDD): DD/MM/YYYY (when applicable)

Patient Details and Demographics

Health Card #: VC: Province issuing Health Card:
No Health Card #: ☐ No Version Code: ☐

Surname:	Given Name(s):	
Home Address: No Known Address: ☐	City:	Province:
Postal Code:	Tel #:	Alternate Tel #:
Address for Treatment: (Complete if different from Home Address):	City:	Province:
Postal Code:	Tel #:	Alternate Tel #:
Date of Birth: DD/MM/YYYY	Gender: ☐ M ☐ F	

Patient speaks/understands English: ☐ Yes ☐ No Interpreter required: ☐ Yes ☐ No
Primary language: ☐ English ☐ French ☐ Other:_____

Primary Alternate Contact Person:
(Please Check All Applicable Boxes) Relationship: ☐ POA ☐ SDM ☐ Spouse ☐ Other:_____
Tel #: Alternate Tel #: No Alternate Tel#: ☐

Secondary Alternate Contact Person: None provided: ☐
(Please Check All Applicable Boxes) Relationship: ☐ POA ☐ SDM ☐ Spouse ☐ Other:_____
Tel #: Alternate Tel #: No Alternate Tel#: ☐

Health Information

Community Health Care Provider (e.g. MD or NP) ☐ None	Surname:	Given Name(s):

Relevant Diagnosis for Referral:

Reason for Referral:

Allergies: ☐ NKA ☐ Yes --- if Yes, List Allergies:

Infection Control: ☐ None ☐ MRSA ☐ VRE ☐ CDIFF ☐ ESBL ☐ TB ☐ Other (Specify):_____

Attachment(s): ☐ None ☐ Medical Orders ☐ Primary Care ☐ InterRAI-PS ☐ Other(Specify):_____

Referring Organization Information

Referring Organization/Unit: Organization Contact Number:
Completed By: Title: Date: DD/MM/YYYY
Contact Tel #: Email address:

Eligibility for Direct Services: Valid OHIP card; Assessment by a CCAC Health Care Professional.

If Faxed include Number of Pages (Including Cover): _____ Pages

Champlain CCAC Community Care Access Centre / CASC Centre d'accès aux soins communautaires de Champlain

CCAC Referral – Primary Care Addendum

Last Name, First name: _____ HCN: _____ VC: _____

Detailed Health Information	
Primary Diagnosis	
Secondary Diagnosis	

PROGNOSIS	DIAGNOSIS DISCUSSED	PROGNOSIS DISCUSSED
☐ Improve ☐ Remain Stable ☐ Deteriorate ☐ Maintenance	With Patient ☐ Yes ☐ No With Family ☐ Yes ☐ No	With Patient ☐ Yes ☐ No With Family ☐ Yes ☐ No

Relevant Medical History	
Surgical or other Procedures	
Medication	
Diet	
Allergies	

Services Requested	Notes, Orders, and Contraindications
	Treatment will be taught and reduced unless otherwise indicated.
☐ Care Coordination ☐ Nursing ☐ Personal Support/Care ☐ Physiotherapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Dietician ☐ Social Work	

Signature of Physician	
Signature:	Date:
Physician Name:	