East End Community Health Centre

1619 Queen Street East, Toronto, Ontario M4L 1G4
Tel: 416-778-5858 Fax: 416-778-5855
www.eastendchc.on.ca

REFERRAL DATE (Day/Month/Year):
_____/_____/_____

REFERRAL, CONSULTATION REQUEST – CHIROPODY AT EAST END CHC

ELIGIBILITY

Please note that to be accepted, clients must provide a Government Notice of Assessment.

1. **Does the client have Extended/Private Health Insurance or is able to afford care?** ☐ Yes ☐ No
   If yes, *please ask reception for the list and refer to External/Private Chiropody clinics.*

2. **Does the client currently receive any benefits or income support?** ☐ Yes ☐ No
   If yes, please specify the benefit(s):
   ☐ ODSP –Ontario Disability Support Program ☐ OW – Ontario Works
   ☐ CPP – Canada Pension Plan ☐ OAS – Old Age Security
   ☐ Other *(please specify)*: _____

3. **Does the client live in the East End Community Health Centre catchment area?** ☐ Yes ☐ No

East End Community Health Centre provides priority access to people living ***within*** the yellow boundaries on this map:

- **Western boundary:**
  Greenwood Avenue (south of Danforth Ave) and Coxwell Avenue (north of Danforth Ave)
- **Eastern boundary:**
  Victoria Park Avenue
- **Northern boundary:**
  O'Connor Drive to St. Clair Avenue
- **Southern boundary:**
  Lake Ontario.

For more information visit: https://eastendchc.on.ca/who-we-serve/

4. **Does the client have any high-risk medical condition?** ☐ Yes ☐ No
   If yes, please specify the high-risk condition(s):
   ☐ Diabetes ☐ Risk of Infection ☐ Poor Circulation ☐ Previous Stroke ☐ Severe RA
   ☐ Heart Attack ☐ Immune Deficiency ☐ Other *(please specify)*: _____

If you answered yes to questions 2 – 5: *Please continue filling the form.*
Otherwise, ask reception for the list and refer to External/Private Chiropody clinics.

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REFERRING PROVIDER INFORMATION	PATIENT INFORMATION
Referred by: _____	**Name:** _____
Urgency: _____	**Date of birth:** Day: _____ Month: _____ Year: _____
Please provide primary physician contact information	**Address:** _____
Provider: _____	_____
Phone: _____	**Health card#:** _____
Fax: _____	**Phone:** _____

LANGUAGE

5. **Does the client require language interpretation services?** ☐ Yes ☐ No

If yes, *please indicate the preferred language:* _____

CLINICAL INFORMATION

6. **Does the client have foot pain/ pathology that may require custom foot orthotics?** ☐ Yes ☐ No

7. **Reason for referral/Foot complaint:** ☐ Skin lesion/pathology ☐ Foot pain
   - ☐ Diabetic foot assessment with foot pathology/ foot complaint
   - ☐ Diabetic foot assessment with no foot pathology/foot complaint
   - ☐ Other *(please specify)*: _____

8. **Mobility Issues?** ☐ Yes ☐ No

   If yes, please specify the mobility issue:

   ☐ Cane ☐ Walker ☐ Wheel chair ☐ Scooter ☐ Housebound

   ☐ Other *(please specify)*: _____

9. **Does the client identify with any of these challenges?**
   - ☐ Mental Health Challenges ☐ Developmental challenges ☐ Chronic/disabling illness
   - ☐ Problematic drug and or alcohol use ☐ Homeless/ marginalized
   - ☐ Other *(please specify)*: _____

10. **Current medications** *(please list)*

_____

_____

_____

At this time due to limited resource, East End CHC can NOT provide home visits.