Good Foot Forward

Provider Referral Form

Eligibility:

1. **No access to foot care (i.e. no extended health benefits or ability to pay privately).**
2. **Moderate Risk Criteria** with or without loss of protective sensation as per the assessment & triage tool.

Referral Date: dd-mm-yyyy

Please fax completed form to: **705-797-2921**

Full Name:

Legal name if different:

Date of Birth: dd-mm-yyyy

Address:

Person's Phone Number:

Health Card Number:

VC:

Indigenous Self-Identification:

☐ First Nation (Status) ☐ First Nation (non-Status) ☐ Métis ☐ Inuit Other:_____

Patient Information

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ No Diabetes

Peripheral Arterial Disease ☐ Yes ☐ No

Provider Information

Assessment and Triage Form Completed ☐ Yes ☐ No

Referring provider's name (diabetes educator, nurse, etc.):

Physician/Nurse Practitioner Name:

Physician/Nurse Practitioner Office Phone:

Physician/Nurse Practitioner Office Address: