Appendix Referral Form

☞ **This is an example from ARC Program. Please adapt it for your setting.**

ARC Community Resource Referral Form

ARC Research Team Contact information:

Tel: 613-562-6262 ext. 2920 **Fax: 613-782-2777**

Complete this form ONLY if the patient consents to be contacted by a member of the study team at Bruyère Research Institute in Ottawa, Ontario.

Name: _____	**Telephone #:** (__ __ __) __ __ __ - __ __ __ __ **Best time: ☐ AM ☐ PM ☐ Evenings ☐ Weekends** **☐ Other** _____
☐ Male ☐ Female ☐ Other	**Age: _____ years**

☐ The patient agrees to have their name and telephone number sent to the researchers in Ottawa so they can be contacted to receive more information about the ARC study.

☐ The patient was provided with the study information package and the research team's contact information.

Please select one option:

☐ Able to communicate with research team in French or English

Preferred language for contact:

☐ French ☐ English

☐ Requires interpretation services *please specify:* _____

☐ Requires support from parent or proxy. *Proxy Contact Information:*

Name: _____ Telephone #: _____

Seeking resources to address the following needs:

☐ Chronic pain	☐ Diabetes education	☐ Mental health
☐ Physical activity	☐ Stop smoking	☐ Addiction
☐ Healthy eating	☐ Parenting and family support	☐ Self-management

☐ Other (specify):

Additional Comments
Main Responsible Provider's name: _____ Referring Provider's name (Please Print): _____ Signature: _____ Date: 201_/_ _/_ _ Year / Month / Day