Winnipeg Regional Health Authority — Caring for Health
Office régional de la santé de Winnipeg — À l'écoute de notre santé

TICK COLLABORATIVE CARE SERVICE REFERRAL FORM

Referral by Fax: 204-940-1686 Phone: 204-940-1975

Client Health Record #
Client Surname
Given Name
Date of Birth
Gender
MFRN
PHIN
Address

Referral Criteria:

1. Client has primary care provider.
2. Three common tick borne symptoms present for greater than three months.
3. Age greater than or equal to 17 years.

Clients will be notified of receipt of referral. Please complete and submit this form and referral letter together with required information. Lack of pertinent information may delay scheduling of client's appointment.

Client Information:

Mailing Address ______
City ______ Postal Code ______
Primary Phone ___ - ___ - ___
Secondary Phone ___ - ___ - ___
Client Primary Language ______
Is an interpreter required ☐ Yes ☐ No

Referring Practitioner:

Name ______
Clinic ______
Address ______
MyHealth Team ☐ Yes ☐ No
Phone ___ - ___ - ___
Fax ___ - ___ - ___

Referral Information to be completed and signed by referring practitioner:

Diagnosis ______ ☐ Confirmed (attach result) ☐ Presumed

Guidelines listed on page 2:

- ☐ 1. Attach medical history including medications and allergies
- ☐ 2. Attach Baseline Investigations including Electrocardiogram
- ☐ 3. Attach Timeline Specific Investigations
- ☐ 4. Attach Blood Work

Symptoms *(Identify all present for greater than three months)*:

- ☐ Anemia
- ☐ Arthritis/Joint Pain
- ☐ Atrioventricular Block Fatigue
- ☐ Cognitive Difficulties
- ☐ Decreased Coordination
- ☐ Depression
- ☐ Dizziness
- ☐ Erythema Migrans Rash
- ☐ Fasciculation
- ☐ Fatigue
- ☐ Fever/Chills
- ☐ Headache
- ☐ Increased Liver Function Test
- ☐ Irritability
- ☐ Leukopenia
- ☐ Musculoskeletal Pain
- ☐ Nausea
- ☐ Neuralgia/Paresthesia/Nerve Palsy
- ☐ Photophobia
- ☐ Sleep Disturbances
- ☐ Thrombocytopenia
- ☐ Tick Bite
- ☐ Visual Disturbances
- ☐ Other *(please describe)*

______ Signature
______ Printed Name and Designation
Date D D M M M Y Y Y Y

Information required by Tick Collaborative Care Service (TiCC Service):

1. **Medical History**

   Demographic information including phone number(s)
   Medical History
   Co-existing medical conditions
   Allergies, if no allergies indicate no known allergies.
   List of current medications (prescription, over the counter, vitamins, herbal supplements)

2. **Baseline Investigations**

   Borrelia Burgdorferi Antibody Screen at Cadham Provincial Lab. Indicate on requisition if client has traveled to Europe in past 6 months.
   Syphillis Test: screened by a Treponema Pallidum-specific assay
   Electrocardiogram *(Current within 1 year)*

3. **Timeline Specific Investigations**

   Anaplasma Antibody Screen – *Only indicated if symptoms present LESS than 6 months*
   Babesia Ab Serology – *Only indicated if symptoms present LESS than 12 months*

4. **BLOOD WORK** *(Current within 6 months)*

   Complete blood count and differential
   Biochemistry: Sodium, Potassium, Chloride, Urea, Creatinine, Calcium
   Liver Function/Enzymes: Total Protein, Albumin, Alk Phos, ALT, AST
   Antinuclear Antibody Test, Erythrocyte Sedimentation Rate, C-Reactive Protein

Instructions for Preparing and Submitting TiCC Service Referral:

Complete the TiCC Service Referral directly within the EMR or alternatively it can be printed and ordered through Shared Health Printing Services and/or forms can be printed directly from Insite.

Attach the “required referral information” specific to the TiCC Service Referral that is detailed on page 1.

1. The addressograph will auto-populate in the EMR. If using paper it can be handwritten or a label applied with all the required information.
2. Complete address, temporary address if applicable, and phone numbers (primary and secondary) as this is vital information to ensure that the client can be contacted.
3. Current Medications & Supplements: complete name, dose and schedule for all medications client is taking.
4. Accompanying Documentation required: check off each item that is being sent with referral form to ensure that all information has been included. All items listed are required by the program.
5. Completed by: (Print)/(Signature) of referring practitioner completing the form. Used by TiCC Service Program nurse as contact for more information when/if required.
6. Date: Date the form in DD/MMM/YYYY format once form has been completed. This referral form will become a part of the client’s chart and should include the date the information was transferred to the TiCC Service.