Telemedicine IMPACT Plus
Interprofessional Complex Care Clinic

**What is TIP?**

Telemedicine IMPACT Plus offers one-time interprofessional consultations to **complex patients** and their **family physician** to coordinate care planning and derive new solutions for addressing the patient’s chronic conditions.

The physician, patient, and caregivers also benefit from the support of a dedicated nurse who coordinates the patient’s circle of care.

Across the TC LHIN, each TIP consulting team has a core membership (as required) of a:

- Psychiatrist
- Internist
- Pharmacist
- Social worker
- CCAC Coordinator
- Dietician

Some of our teams offer specialty consults in:
- Geriatrics
- Geriatric psychiatry
- Diabetes
- Endocrinology

*TIP is an OHIP-billable service.*

**Which patients do I refer?**

- Medically complex patients with multiple chronic conditions and medications
- Frequently hospitalized patients in need of access to psychiatric, mental health, or social supports
- Patients who could benefit from coordinated care planning

**Why should I refer to TIP?**

- Access psychiatric and internist consultation within weeks or sooner
- Develop a Coordinated Care Plan
- Navigate health and community resources with a dedicated nurse
- Gain the necessary supports to help manage the complex patients who “keep you up at night”

To refer a patient, please complete the attached referral form.
Date of referral: _______ M M / D D / Y Y

Source of referral (if other than primary care physician/nurse):

If applicable, please specify your preferred TIP clinic location/team:

Does the patient’s family physician or nurse practitioner consent to participating in TIP? Yes___ No___

Name of referring primary care provider (i.e. GP or NP):

Primary practice street address only: ________________________________OHIP Billing No.: __________

Phone: ___________________ Fax: _____________________ Email: __________________

Patient last name: __________________________ Patient first name: __________________

OHIP#: ______________________________ DOB: _______ M M / D D / Y Y Age: ___ Sex: ___

Street address: ______________________________ Phone: ___________________ Can we leave messages

If a family member will be participating as the patient’s substitute decision maker:

Caregiver name: ________________ Relationship to patient: _______________ Phone: __________________

Referral checklist:

1) Does the patient (pt) consent to participating in a TIP clinic? Yes___ No___
2) Does the pt or caregiver speak English? Yes___ No___
3) Is the pt currently on 5 or more medications? Yes___ No___
4) Does the pt have 2 or more chronic conditions? Yes___ No___
5) Is this pt’s care difficult to manage due to complications of co-existing conditions? Yes___ No___
6) Does the pt suffer from mental health or substance use issues? Yes___ No___
7) In your medical opinion, does the patient visit the hospital/ED often? Yes___ No___
8) Is the pt currently in hospital? Yes___ No___
9) Will the pt be transferred to ALC or is long-term care imminent? Yes___ No___
10) Does the pt have diabetes? Yes___ No___
11) Is the pt considered geriatric? Yes___ No___
12) Is the pt a CCAC client? Yes___ No___
13) Is the pt considered palliative? Yes___ No___

Priority issues—identify the top 3 questions you would like addressed during this 1-hr consult:

Please fax completed referral form to 1(888) 401-6675