



Referral Form (Community and Individual)

Please complete all appropriate sections

Date: (DD/Month/YYYY) _____

1. Basic Demographic Information

Full Name (First / Middle / Last) (as appears on Health Card)

Preferred First Name (if different):

Date of Birth (DD/Month/YYYY)

I would identify myself as:

☐ First Nation (Status) ☐ First Nation (Non-Status) ☐ Métis ☐ Inuit

☐ Other (please identify): _____

My FN Status Number (Registration Number or Métis Membership # or Inuit ID Number is:

Do you identify as a member of the LGBTQ+ community? ☐ Yes ☐ No ☐ Other: _____

If you are a person with a Disability **please identify any accommodations** required for your appointment.

Health Card NO:

Sex:

Version Code

Expiry Date

2. Address and Contact Information

Street:

City

Postal Code

Primary Phone #: ☐ Mobile ☐ Work ☐ Home

Alternate Phone # ☐ Mobile ☐ Work ☐ Home

Email Address:

Preferred means of communication:

☐ Mobile ☐ Work ☐ Home ☐ Text (Consent required) ☐ Email (Consent required)

Mailing Address (Alternate Address) ☐ Same as above or

Street:

City

Postal Code

Emergency Contact:

Name:

Relationship:

Primary Phone #: ☐ Mobile ☐ Work ☐ Home

Do you have a Substitute Decision Maker (SDM)/Power of Attorney(POA) for Medical/Personal Care?: ☐ Yes ☐ No

SDM/POA Name:

Relationship:

Primary Phone #: ☐ Mobile ☐ Work ☐ Home

3. Referral Information		
☐ Self / Family / Friend ☐ Justice System ☐ Mental Health Services ☐ Hospital / Medical Services ☐ Other Community Service Agency: _____ ☐ Internal SOAHAC Referral		
Referral Source:		Contact Name:
Phone Number:	Email:	
4. If completing forms for child or youth (under 18) Please provide the following information, otherwise continue to section 5.		
Legal Guardian (s):		
Relationship to child / youth:		
Child is Residing with: ☐ Both Parents ☐ Mother ☐ Father ☐ Caregiver ☐ Relative: _____ ☐ Foster Parent(s) ☐ Group Home ☐ Other: _____		
Agency Involvement: ☐ CAS/Band Rep ☐ Ontario Works ☐ N'Amerind ☐ SOAHAC ☐ At^Lohsa ☐ Other: _____		
If CAS is involved. Please provide the following. Agency Name: Worker(s) assigned to family, include contact information? Identify what type of agreement is in place. ☐ Customary Care ☐ Kinship Care ☐ Foster Care ☐ Temporary Care		
4a. Caregiver (Primary) Contact Information		
Full Name (First / Last):		
Street:	City:	Postal Code:
Primary Phone #: ☐ Mobile ☐ Work ☐ Home	Alternate Phone # ☐ Mobile ☐ Work ☐ Home	
Relationship:		
4b. Caregiver (Additional) Contact Information		
Full Name (First / Last):		
Street:	City:	Postal Code:
Primary Phone #: ☐ Mobile ☐ Work ☐ Home	Alternate Phone # ☐ Mobile ☐ Work ☐ Home	
Relationship:		
4c. Education		
School:	Grade:	School Board:

5. Do you presently have a Family Physician/ Nurse Practitioner? ☐ Yes ☐ No

Provider's Name: _____

- Do you presently see a Traditional Healer/Elder? ☐ Yes ☐ No

Healer/Elder's Name: _____

- Do you presently see a Mental Health Provider? ☐ Yes ☐ No

Provider's Name: _____

6. I am requesting the following Integrated Wholistic Care Service(s):

- ☐ **Traditional Healing.** If yes, please indicate your reason for seeking Traditional Healing Services Care?

☐ Prefer not to answer

- ☐ **Mental Health Services for Adults or Children.** If yes, please indicate your reason for seeking Mental Health Services.

☐ Prefer not to answer

- ☐ **Clinical Services (including Doctor, Nurse Practitioner, Dentist, Dietitian, Diabetes Team, FASD, SASH).** If yes, please indicate your reason for seeking Clinical Services and **include a list of current medications.**

☐ Prefer not to answer

I am seeking services at the following location:

☐ Chippewa 77 Anishinaabeg Drive Muncey, ON N0-L 1Y0 Confidential Fax: 519-289-0355	☐ London 425-427 William ST London, ON N6B 3E1 Confidential Fax: 519-672-7220	☐ SOAHAC – Newbury Four Counties Hospital Site Confidential Fax: 1-877-452-5114
☐ Owen Sound 3 – 733 9 th Ave E Owen Sound, ON N4K 3E6 Confidential Fax: 519-376-1845	☐ Waterloo Wellington 102 – 745 Coronation BLVD Cambridge, ON N1R 7R1 Confidential Fax: 1-519-623-2929	☐ Windsor 2 – 1405 Tecumseh RD W Windsor, ON N9B 1T7 Confidential Fax: 1-519-916-1756

For internal use only. To be completed by SOAHAC staff (please complete, date and initial)

Referral was received:

Date (DD/Month/YYYY) _____ Name: _____ Initials: _____