Southwest Ontario Aboriginal Health Access Centre

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 LGBT2Q+ 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: 519-672-6945	☐ **SOAHAC – Newbury** Four Counties Hospital Site Confidential Fax: 226-799-0289
☐ **Owen Sound** 3 – 733 9th Ave E Owen Sound, ON N4K 3E6 Confidential Fax: 519-376-1845	☐ **Waterloo Wellington** 102 – 745 Coronation BLVD Cambridge, ON N1R 7R1 Confidential Fax: 519-623-2929	☐ **Windsor** 2 – 1405 Tecumseh RD W Windsor, ON N9B 1T7 Confidential Fax: 519-253-6567

For internal use only. To be completed by SOAHAC staff (please complete, date and initial)
Referral was received: Date (DD/Month/YYYY) _____ Name: _____ Initials: _____