Ontario

HealthLinks

REFERRAL FORM

This referral form will assist in identifying those who are eligible for Health Links Coordinated Care Planning.

Demographic Information			
Given name:	Preferred name:	Surname:	
Date of birth (DD/MM/YYYY):		Gender: Preferred pronoun:	
Health card number:			
Address:			
City:	Province:	Postal code:	
Telephone number:	Alternate telephone number:		
Ancestry/culture:			
Identify as First Nation, Métis, or Inuit? ☐ Yes ☐ No	If "yes," specify which nation:		
Language of comfort:	Communication accommodations:		
Name of contact person (if other than patient):			
Telephone number:	Relationship to individual:		

Referral Source	
Name of Agency:	Primary Care Provider:
Contact Person:	Phone:
E-mail:	Fax:

STOP *Do not submit this form without the individual's verbal consent to proceed with a referral to Health Links. If the individual declines consent, please keep this document on your agency file for reference.*

- ☐ Obtained verbal consent on (DD/MM/YYYY): _____
- ☐ Provided Patient with HL Information Sheet and Workbook
- ☐ Confirmed social determinants of health
- ☐ Confirmed 4+ Co-morbidities

Main Reason for Referral

Other agencies/primary care provider/services involved (if known)(attach additional pages if required)		
Agency:	Contact Name:	Contact Number/email:

Printed Name _____ Signature _____ Date (DD/MM/YYYY) _____

Fax completed referrals to: North East LHIN Home and Community Care: