North West Local Health Integration Network
Réseau local d'intégration des services de santé du Nord-Ouest

NW LHIN Referral

Patient Identification

If Faxed Include Number of Pages (Including Cover): _________ Pages

Estimated Date of Discharge (EDD): DD/MM/YYYY

Patient Details and Demographics

Health Card #: Version Code: Province Issuing Health Card:

No Health Card #: ☐ No Version Code: ☐

Surname: Given Name(s):

No Known Address: ☐ Home Address: City: Province:

Postal Code: Telephone : Alternate Telephone: No Alternate Telephone: ☐

Address for Treatment: (Complete if Different From Home Address)
City: Province:

Postal Code: Telephone: Alternate Telephone: No Alternate Telephone: ☐

Date of Birth: DD/MM/YYYY Gender: ☐ M ☐ F ☐ Other

Patient Speaks/Understands English: ☐ Yes ☐ No Interpreter Required: ☐ Yes ☐ No

Primary Language: ☐ English ☐ French ☐ Other

Primary Alternate Contact Person:

(Please Check All Applicable Boxes) Relationship: ☐ POA ☐ SDM ☐ Spouse ☐ Other

Telephone: Alternate Telephone: No Alternate Telephone: ☐

Health Information

Community Primary Health Care Provider: (e.g. MD or NP) ☐ None Surname: Given Name(s):

Relevant Diagnosis for Referral: (*Please Include any Surgical Procedure(s) and Date(s)*)

Reason for Referral: (Please note that nursing requires MD/NP Orders and IV referrals require the IV referral form)

☐ Nursing ☐ Nurse Practitioner ☐ Personal Support ☐ Physiotherapy ☐ Occupational Therapy ☐ Social Work ☐ Nutrition

☐ Speech-Language Pathology ☐ Case Management ☐ Rapid Response ☐ Telehomecare ☐ Chronic Disease Self-Management

☐ Request for Assessment

Allergies: ☐No Known Allergies ☐ Yes --- If Yes, List Allergies:

Infection Control: ☐ None ☐ MRSA ☐ VRE ☐ CDIFF ☐ ESBL ☐ TB ☐ Other (Specify)________________________________

Medical Orders: ☐ No ☐ Attached IV Orders: ☐ No ☐ Attached

Referring Facility/Unit: Facility Contact Number:

Completed By: Title: Date: DD/MM/YYYY

Contact #:

CONFIDENTIAL WHEN COMPLETED. IF YOU HAVE RECEIVED THIS FORM IN ERROR PLEASE DO NOT COPY OR DISPOSE. PLEASE CONTACT (807) 345-7339 AND WE WILL MAKE ARRANGEMENTS TO COLLECT IT.

Guidelines for Use Form #762

1. The Referral for NW LHIN Services form is a communication tool between the LHIN and the client's primary care provider.
2. The form is completed when the primary care provider wishes to:
   a. refer a client for services in the community and/or
   b. communicate the current medical condition of the client.
3. Once completed, the form is transmitted to the LHIN office to initiate an assessment by the Community Care Coordinator. The second copy may be retained by the hospital or primary care provider's office for their records
   a. After regular business hours, or on the weekend, the form must be faxed to the LHIN office (fax # 346-4625)
4. Upon receipt of a referral, the Community Care Coordinator must determine the client's eligibility for services.
   a. If the client is eligible for Community Care services, the Coordinator may:
      i. Alter the frequency of treatment requested by the primary care provider, as indicated by circumstances,
      ii. Arrange for teaching of the client or caregiver
      iii. Request an assessment from other LHIN disciplines.
   b. If the client is not eligible, the referral will be processed as a non-admit and the client may be referred to other health care services.

North West LHIN

Thunder Bay
Tel: 1-807-345-7339
Fax: 1-807-346-4625

Geraldton
Tel: 1-807-854-2292
Fax: 1-807-346-4625

Marathon
Tel: 1-807-229-8627
Fax: 1-807-346-4625

Dryden
Tel: 1-807-223-5948
Fax: 1-807-223-3943

Kenora
Tel: 1-807-467-4757
Fax: 1-807-468-4785

Fort Frances
Tel: 1-807-274-8561
Fax: 1-807-274-0844

Sioux Lookout
Tel: 1-807-737-2349
Fax: 1-807-737-3017

Red Lake
Tel: 1-807-727-3455
Fax: 1-807-727-2484

Atikokan
Tel: 1-807-597-2159
Fax: 1-807-597-6760

Rainy River
Tel: 1-807-852-3955
Fax: 1-807-852-1077

Nipigon
Tel: 1-807-887-5862
Fax: 1-807-346-4625