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| **Refugee Health ICT Referral Form** | | | | |
| Date: | Family Referral  Individual Referral | | | Has the Patient/ Family given their consent for us to contact them?  Verbal Consent  Consent Attached |
| Family Name/ Patient Name/ Gender/ Pronouns/ OHIP#’s/ IFH #/ Address/ DOB/ Primary Phone #  Place Patient Label Here | | Family Name/ Patient Name/ Gender/ Pronouns/ OHIP#’s/ IFH #/ Address/ DOB/ Primary Phone #  Place Patient Label Here | | |
| Family Name/ Patient Name/ Gender/ Pronouns/ OHIP#’s/ IFH #/ Address/ DOB/ Primary Phone #  Place Patient Label Here | | Family Name/ Patient Name/ Gender/ Pronouns/ OHIP#’s/ IFH #/ Address/ DOB/ Primary Phone #  Place Patient Label Here | | |
| Emergency Contact: | | | | |
| Primary Physician: | | | Phone: | |
| Interpretation Required? Yes  No | | | Preferred Language: | |
| **Please check off areas of concern (Describe any selected below):** | | | | |
| ☐Medication Management  Medication Review  Medication Education  Disease monitoring and support: smoking cessation, ………diabetes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐Symptoms of Mental illness  ☐Addictions  ☐Transportation/ Navigating the City  ☐Home or Community Supports (Ex. OT, PT, PSW etc.)  ☐Food Security  ☐Grief Support  ☐Access to English Language Programs | | | ☐Financial Concerns  ☐Housing Concerns  ☐Abuse/ Relationship Concerns  ☐2SLGBTQ+ concerns  ☐Social Isolation  ☐Community/ Cultural Services  ☐Legal Concerns  ☐Employment Support  ☐Support with Appointment Attendance  ☐ID Support (ex. Health card, birth certificate)  Education  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Additional Information/ Current Supports:** | | | | |
| **Do you require an update?**  **Fax  Phone** | | **For Office Only**  **Date of Client Contact:** | | |
| **Please Fax referrals to: 519-578-2109 or complete a phone referral by calling 1-519-500-5083.** | | | | |
| **CFFM-Joseph Street Site**  **25 Joseph Street**  **Kitchener, Ontario N2G 4X6**  **Fax: 519-578-3366** | | | | |