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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**  |