Health Guide Services Referral Form

Central Intake Fax Number: (519) 621-8688 or 1-844-237-5240

Health Guide Phone: 519-653-1470 ext. 354

Eligibility: Age 16+ and Patient must have Primary Care Provider or be seeking Primary Care in Cambridge/North Dumfries area. **Completing, signing, and sending this form indicates patient consents to being contacted and/or left messages by a health guide team member**

Legal Last Name:_____ Legal First Name: _____

Middle Name: _____ Preferred Name: _____ Pronouns: _____

Address: _____ City: _____ Postal Code: _____

DOB (dd/mm/yy): _____ Sex: ☐ Male ☐ Female ☐ X _____

Language Barrier: ☐ YES ☐ NO Language Spoken: _____

Health Card #:_____ Preferred Method of Communication: ☐ Phone ☐ Text

Telephone: _____ Secondary Contact Name and Phone Number: _____

Email:_____ _____

***Primary Care Provider:** _____ **Primary Care Provider Phone:** _____

Service Coordination Needs	☐ AUA risk assessment (*for Delta FHO Only*)
☐ Form/Application navigation and assistance	☐ Connection to Food Resources
☐ Financial/Benefit eligibility checks	☐ Connection to Education Supports
☐ Connection to community housing agencies	☐ Finding Primary Care
☐ Connection to public and specialized transportation services	☐ Connection to Counselling Services
☐ Connection to mental health and addiction services	☐ Connection to Translation Services
	☐ Connection to Caregiving Supports

*** Reason for Referral** *(please provide as much information as possible):*

Barriers to Care

☐ Physical health issues	☐ Cultural barriers
☐ Mental health and addiction issues	☐ Employment issues
☐ Neurodevelopment disorders (please specify)	☐ Lack of communication methods (ie. no phone, no internet)
☐ Unhoused	
☐ Language/Literacy/Education	☐ Limited support from family/peers/social isolation

Additional Information

☐ Abuse/safety concerns – please provide information regarding domestic violence concerns if known.

☐ In home safety issues – smoking, pets, bed bugs etc. if known.

☐ Other clinical information attached (history, progress notes).

*** Referring Provider Information:**

Name: _____ Profession: ☐ Hospital ☐ Other

Address: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

Save As Print Reset Form

June 2024