Sioux Lookout First Nations Health Authority

ADULT HEALTH SERVICES INTAKE/REFERRAL FORM

INTAKE/REFERRAL FORM FOR THE FOLLOWING SLFNHA DEPARTMENTS:

- *SLFNHA – Developmental Services*
- *SLFNHA – Primary Care Team*

***Mandatory Fields**

Name:	DOB (dd/mmm/yyyy): Gender: M ☐ F ☐ O ☐
Community:	Contact #:
Health Card #:	Status Card #:
Alias/Anishinaabe Name:	Clan:
Physical Address:	
Mailing Address (☐ Same as physical):	
If family/client does not have phone, OK to leave non-detailed message at:	Name: _____ Contact #:
Preferred Language:	Interpreter Required? ☐Yes ☐ No Language:

NOTE: **WE CANNOT ACCEPT REFERRALS THAT REQUIRE NIHB TRAVEL WITHOUT THIS INFORMATION**

Referral Selections: Identify which program(s) the client is being referred to:

*Please Note: The following services can all be **requested for consideration**; however, the client's suitability/eligibility for some programs will be determined by their respective agencies and cannot be guaranteed.*

Please indicate priority level: ☐ **URGENT (1-3 Weeks)** ☐ **1-3 Months** ☐ **Waitlist**

Adult Services	
☐ Dietitian ☐ FASD Diagnostic Assessment ☐ Foot Care ☐ Hepatitis C Treatment ☐ Kinesiology ☐ MMW (Mashkikiiwininiwag Mazinaatesijigan Wichiiwewin) /Transitions Program - Adult DSO ☐ Occupational Therapy	☐ Pharmacy ☐ Physiotherapy ☐ Pelvic Floor ☐ Vestibular/Vertigo ☐ Speech Language Pathology Wound Care

MANDATORY SECTION

Client/Guardian signature: _____Date: _____

Alternatively: *Referring Party has spoken* **directly** *to client/guardian to discuss this referral and has received* ***verbal consent*** *to initiate this referral.* → ***Referring Party Initials*** ____

Reason for Referral:

Please provide a brief description of the problem/concern *(To assist in the referral process, if the client consents, please also attach any relevant medical, psychological, rehabilitation, behavioral assessments and reports etc., including those that identify a previous diagnosis)*:

Please submit the fully completed form to our Central Intake Fax Line at 1 (807) 737-8130

Client's Name	Date of Birth (YYYY//MM/DD)

Referring Party Information	
Name:	Date:
Agency:	Phone #:
Email:	Fax #:

Other Service Providers, Agencies, Physicians, Community Resources Involved? Please list as many as possible: ☐ None

Does the client/family require any assistance or accommodations in order to participate in a **telephone meeting** with an Intake worker? (i.e. Access to a telephone, Wheelchair Accessibility, documents in large type or Braille, modified speed and volume of speech, specific appointment scheduling to allow for regular medical routines etc.).
If yes, please have the client/family member describe what accommodations would best assist them: ☐ No

Does the client/family require any assistance or accommodations in order to participate in **any future services** the client/family may select after the intake meeting is completed? (i.e. Wheelchair Accessibility, documents produced in large type or Braille, access to text-to-speech software, specific appointment scheduling to allow for regular medical routines, meetings held in their own home etc.) ☐ No

Any other information that is important or helpful regarding this referral?

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