Sioux Lookout
First Nations
Health Authority

Primary Care Team
Intake/Referral Form (Adult)

Name:	DOB (dd/mm/yyyy):
Community:	Sex: ☐ Male ☐ Female ☐ Other:
Health Card #:	Home #:
Status Card #:	Cell Phone #:
Alias/Anishinaabe Name:	Other Phone #:
Is client aware of referral? ☐ Yes ☐ No	Email:
Preferred Language:	Interpreter Required? ☐ Yes ☐ No
Mailing/Physical Address:	
If family/client does not have phone, okay to leave non-detailed message at:	Name:_____ Contact #:_____
Does client have difficulties with: ☐ Mobility ☐ Hearing ☐ Speech ☐ Vision ☐ Other/Specify Below:	
Specify:	

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.

Adult Services

☐ Dietitian
☐ FASD Diagnostic Assessment
☐ Foot Care
☐ Hepatitis C Treatment
☐ Kinesiology
☐ Occupational Therapy
☐ Pharmacy
☐ Physiotherapy
  ☐ Pelvic Floor Therapy
  ☐ Vestibular/Vertigo
☐ Speech Language Pathology
☐ Wound Care **Please fill out an NW Regional Wound Care Central Intake Referral**
☐ Smoking Cessation Program **Existing PCT Clientele only**

Referring Party Information

Name:	Date:
Agency:	Phone #:
Email:	Fax #:

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, rehabilitation, lab, diagnostic imaging, medications, and other reports etc.**, including those that identify a previous diagnosis):

Please submit the fully completed form to our Intake Fax Line at 1 (807) 737-8130
OR email IntakeReferrals@SLFNHA.com

Revised January 2024