CONFIDENTIAL

Sioux Lookout First Nations Health Authority

PEDIATRIC SERVICES

SERVICE APPLICATION (INTERNAL)

(0-17 YEARS 364 DAYS)

Services are provided through Jordan's Principle funding therefore demographic information will be shared with Indigenous Services Canada(ISC).

Please note the application will be triaged to the most appropriate service(s) based on the information provided. This may include deferring to community based programs if appropriate.

(REQUIRED) Verbal Consent:☐ LEGAL GUARDIAN ☐ MATURE MINOR **Referring Party Initials:_____**

Child/Youth

Date of birth: Year:_____Month:_____Date:_____

Name: Last:_____First:_____

Preferred name:_____Pronouns: _____

Community & address: _____

Registration numbers: Band:_____ Health card:_____ Mustimuhw: _____

Guardians/Caregivers

Guardian(s): Name(s):_____Relationship:_____

Phone number(s): (_____)-_____-_____ (_____)-_____-_____

Mailing address: _____

☐ **Same as above** (check box, skip the rest of this section)

Caregiver(s): Name(s):_____Relationship:_____

Phone number(s): (_____)-_____-_____ (_____)-_____-_____

Mailing address: _____

Referring Party

Your name:_____ Title/role:_____

Phone:(_____)-_____-_____ ☐Preferred

Fax:(_____)-_____-_____ ☐ Preferred Signature: _____

Email:_____ ☐Preferred Date: _____

Pediatric Services (0-18) may include:

- Audiology
- Complex Care Navigation
- Dietitian Services
- FASD Diagnostic Clinic
- Foot Care
- Indigenous Liaison (Traditional Services)
- Infant and Child Development Support (0-6 years)
- Occupational Therapy
- Physiotherapy
- Pharmacy
- School and Clinical Psychology
- Speech Language Pathology

Please direct SLFNHA-requested applications for non-developmental related Psychiatric services, Psychology services, Mental Health supports and Counseling to: **Nodin Mental Health Services, using their referral form(s).**

Service applications for Pediatrics or Developmental Pediatrics should be faxed to Pediatric Central intake, Fax (1-855-610-1897)

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Client/Youth name:_____ **Date of birth:** _____

Application details

Support(s) Requested	**Detailed** reasoning for requested support(s) Please include supporting documentation as appropriate.
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Relevant <u>current management</u> (e.g., therapy, medication, lab work, diagnostic imaging):

Additional <u>considerations/information</u> (e.g., language barrier, child protection, sensory/behaviour challenges):

Please attach relevant documentation if not already in Mustimuhw