Main Office
233 S Court St, 1st Floor
Thunder Bay, ON P7B 2X9
Tel: (807) 344-4575
Toll Free: 1-833-625-3611
Fax: (807) 346-2371

Clinic Site
101 Syndicate Ave N, Suite 510A
Thunder Bay, ON P7C 3V4
Tel: (807) 346-2370
Toll Free: 1-833-625-3611
Fax: (807) 346-2371

REFERRAL FORM

☐ Client aware of referral to Matawa Health Cooperative ☐ Consent Forms Attached ☐ Verbal consent given ☐ External ☐ Internal

REFERRANT INFORMATION

☐ Nursing Station ☐ Health Care Provider ☐ Other: (Please specify) _____ Date: _____

Name of Referent: _____ Referent Phone: _____

CLIENT INFORMATION

Last Name:		First Name:	Preferred Name:
D.O.B: DD/MM/YYYY	Sex:	Pronouns:	Health Card Number:
Phone Number:	Email:		Alternate Contact:
Address:		City/Town:	Province:
Postal code:	Community/First Nation: _____		☐ Living in TBay ☐ Status ☐ METIS ☐ NON STATUS

Status Number:

GUARDIAN/ APPOINTED DECISION MAKER INFORMATION

Name:	Phone Number:	Email:

CLIENT HEALTH INFORMATION

☐ Past Medical History Attached ☐ Medication List Attached ☐ Laboratory Test(s) Attached

Allergies:

HEALTH SERVICES

☐ Diabetes ☐ Foot Care ☐ Traditional Healing ☐ STOP Program (smoking cessation)
☐ Dietitian/Nutrition ☐ Primary Care ☐ Wound Care

COMMUNITY/PUBLIC HEALTH SERVICES

☐ Health Education ☐ Pre/Post Natal ☐ Sexual Health (STBBI)
☐ Immunization ☐ School Health Presentation ☐ Health Care Follow-up, In community

MENTAL HEALTH SERVICES

☐ Grief and Loss ☐ Referral and Service Navigation ☐ Suicide Prevention ☐ Youth Services 8 years +
☐ One on One Counselling ☐ Substance Use/ Addiction Concern ☐ Wellness Check

REASON FOR REFERRAL (*e.g. background information re: client*)

PLEASE FAX ALL COMPLETED REFERRAL FORMS TO (833) - 662-2287—Confidential EMR Fax or (807) 346-2371—Confidential Fax