MATAWA HEALTH CO-OPERATIVE

523 Algoma St. N.
Thunder Bay, ON P7A 5C2
Tel: 807-346-2370
Toll Free Tel: 1-833-625-3611
Fax: 807-346-2371
EMR Fax: 1-833-662-2287
www.matawa.on.ca/corporations/matawa-health-co-operative/

REFERRAL FORM

☐ Client aware of referral to MatawaHealth 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 (If Applicable)

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

Allergies:

HEALTH SERVICES

☐ Diabetes/Dietitian/Nutrition ☐ Elder Services ☐ Jordan's Principal ☐ STOP Program (smoking cessation) ☐ Wound Care
☐ Case Management ☐ Foot Care ☐ Midwifery ☐ Primary Care * please fill out Client Application *

COMMUNITY/PUBLIC HEALTH SERVICES

☐ Health Education ☐ Immunization ☐ Pre/Post Natal Care ☐ Sexual Health (STBBI)
☐ Health Care Follow up(in community) ☐ Maternal/Newborn Care/Lactation ☐ School/Community Health Presentation

MENTAL HEALTH SERVICES

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