Cambridge and North Dumfries Health Link Referral Form

Central Intake Fax Number: (519) 621-8688 or 1-844-237-5240
Health Link Phone: (519) 947-1000 or 1-844-204-9088 Press "4"

Last Name: _____ First Name: _____ DOB (dd/mm/yy): _____

Address: _____ City: _____ Postal Code: _____

Telephone: (D) _____ (E) _____ Gender: _____

Health Card Number: _____ Language Barrier ☐ Yes / Language Spoken: _____

Secondary Contact Name and Phone Number: _____

Substitute Decision Maker Name and Phone Number: _____

Primary Care Provider (if different): _____

***Please attach medication and relevant medical history**

REASON FOR REFERRAL – Patient has 4 or more chronic physical and/or mental health conditions

Physical Health Condition			Mental Health Condition			
☐ Hypertension	☐ Diabetes	☐ Frailty	☐ Dementia	☐ Anxiety	☐ Depression	☐ Addiction
☐ Heart Condition/Cardiac	☐ Stroke	☐ Cancer	**Other Physical and/or Mental Health Condition *(Specify)*:**			
☐ Palliative Condition	☐ Arthritis/Fracture	☐ COPD				

Agencies Currently Involved		Services Needed
☐ CCAC	☐ Palliative	**In-Home Services**
☐ Addiction Services	☐ Housing	In-Home Assessment ☐ Yes ☐ No
☐ Justice / Police	☐ Mental Health	In-Home Service Coordination ☐ Yes ☐ No
☐ Social Services	☐ Education	**Community Based Service/Outside the Home:**
☐ Other: _____		Service Coordination ☐ Yes ☐ No

Strengths of Patient

☐ Financial security (employed, CPP, ODSP etc.)	☐ Positive peer / informal supports
☐ Safe and stable housing / neighbourhood	☐ Able to communicate needs
☐ Positive, accessible family supports	☐ Strengths are unknown

Assessment of Urgency

☐ Low Risk *contact within one month	☐ Medium Risk *contact within two weeks	☐ High Risk *contact within one week

Other Information:

Has patient visited the Emergency Department over two times in the past year? ☐ Yes ☐ No ☐ Unknown
Has patient had a hospital admission in the past year? ☐ Yes ☐ No ☐ Unknown

Consent

Referred person consents to this referral ☐ Yes ☐ No
Referred person consents to being contacted and/or left messages by a Health Link team member ☐ Yes ☐ No
Referred person consents to Secondary Contact being contacted by a Health Link member ☐ Yes ☐ No

Signature: _____ **Date: _____**

Print Name/Organization and Address (or stamp):

Phone:

Fax:

Save Referral | Print Referral | Clear Form