



# Health Guide Services Referral Form

**Central Intake Fax Number: (519) 621-8688 or 1-844-237-5240**  
**Health Guide Phone: 519-653-1470 ext. 354**

**Eligibility:** Age 16+ and must live in, receive or be seeking primary care in Cambridge or North Dumfries.  
**Completing, signing, and sending this form indicates patient consents to being contacted and/or left messages by a health guide team member**

Legal Last Name: _____	Legal First Name: _____
Middle Name: _____	Preferred Name: _____ Pronouns: _____
Address: _____	City: _____ Postal Code: _____
DOB (dd/mm/yy): _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Language Barrier: <input type="checkbox"/> YES <input type="checkbox"/> NO	Language Spoken: _____
Health Card #: _____	Preferred Method of Communication: <input type="checkbox"/> Phone <input type="checkbox"/> Text
Telephone: _____	Secondary Contact Name and Phone Number: _____
Email: _____	
<b>*Primary Care Provider:</b> _____	<b>Primary Care Provider Phone:</b> _____

<b>Service Coordination Needs</b>	<input type="checkbox"/> AUA risk assessment <i>(for Delta FHO Only)</i>
<input type="checkbox"/> Form/Application navigation and assistance	<input type="checkbox"/> Connection to Food Resources
<input type="checkbox"/> Financial/Benefit eligibility checks	<input type="checkbox"/> Connection to Education Supports
<input type="checkbox"/> Connection to community housing agencies	<input type="checkbox"/> Finding Primary Care
<input type="checkbox"/> Connection to public and specialized transportation services	<input type="checkbox"/> Connection to Counselling Services
<input type="checkbox"/> Connection to mental health and addiction services	<input type="checkbox"/> Connection to Translation Services
<input type="checkbox"/> Social Prescription (ex. Link to community based activities)	<input type="checkbox"/> Connection to Caregiving Supports

**\* Reason for Referral** *(please provide as much information as possible):*

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**Barriers to Care**

<input type="checkbox"/> Physical health issues	<input type="checkbox"/> Cultural barriers
<input type="checkbox"/> Mental health and addiction issues	<input type="checkbox"/> Employment issues
<input type="checkbox"/> Neurodevelopment disorders (please specify)	<input type="checkbox"/> Lack of communication methods (ie. no phone, no internet)
<input type="checkbox"/> Unhoused	<input type="checkbox"/> Limited support from family/peers/social isolation
<input type="checkbox"/> Language/Literacy/Education	

**Additional Information**

Abuse/safety concerns – please provide information regarding domestic violence concerns if known.

In home safety issues – smoking, pets, bed bugs etc. if known.

Other clinical information attached (history, progress notes).

**\* Referring Provider Information:**

Name: _____	Profession: <input type="checkbox"/> Hospital <input type="checkbox"/> Other
Address: _____	
Phone: _____	Fax: _____
Signature: _____	Date: _____