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 Patient must have Primary Care Provider or be seeking Primary Care in Cambridge/North Dumfries area. **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: ☐ Male ☐ Female ☐ X ____________
Language Barrier: ☐ YES ☐ NO Language Spoken: ______________________
Health Card #:______________________
Telephone: ______________________ Secondary Contact Name and Phone Number: ______________________
Email:______________________________ ____
***Primary Care Provider:** ______________________ **Primary Care Provider Phone:** ______________________

Service Coordination Needs ☐ AUA risk assessment (*for Delta FHO Only*)

☐ Form/Application navigation and assistance	☐ Connection to Food Resources
☐ Financial/Benefit eligibility checks	☐ Connection to Education Supports
☐ Connection to community housing agencies	☐ Finding Primary Care
☐ Connection to public and specialized transportation services	☐ Connection to Counselling Services
☐ Connection to mental health and addiction services	☐ Connection to Translation Services
☐ Social Prescription (ex. Link to community-based activities)	☐ Connection to Caregiving Supports

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

Barriers to Care

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

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: ☐ Hospital ☐ Other
Address: ______________________
Phone: ______________________ Fax: ______________________

Signature: ______________________ Date: ______________________