



**Date:** \_\_\_\_\_  
(DD/MM/YYYY)

**HEALTH SERVICES**

- ☐ Home and Community Care  
(Nursing / Diabetes Ed. / Foot Care)

*For referrals for the above services:*

Fax: (807) 274 – 2050

- ☐ Public/Community Health  
☐ Children's Oral Health Initiative  
☐ Environmental Public Health

*For referrals for the above services:*

Fax: (807) 274 – 8324

- ☐ Child's First Initiative (18 yrs. & under)

*For referrals for the above services:*

Fax: (807) 274 – 2528

**BEHAVIOURAL HEALTH SERVICES**

- ☐ Mental Health Services  
☐ Social Emergencies Services

*For referrals for the above services:*

Fax: (807) 274 – 1010

Email: [bhsintake@fftahs.org](mailto:bhsintake@fftahs.org)

Mental Health Direct Line: (807) 271-0212  
(during regular office hours - call or text)

- ☐ MATW Healing Centre

*For referrals for the above services:*

Fax: (807) 274 – 9941

Email: [bhsintake@fftahs.org](mailto:bhsintake@fftahs.org)

**Client Information:**

Legal First Name:	Last Name:
Preferred First Name:	
Anishinaabe Name:	Clan:
Date of Birth (DD/MM/YYYY):	Gender:
	Preferred Pronouns:
Home Address:	Mailing Address:
City and Province:	City and Province:
Postal Code:	Postal Code:
Home Phone Number and Contact Name:	Child(ren) In Care:
Cell Phone Number and Contact Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Email:	Agency Name:
Health Card #:	Community:
Status Card #:	<input type="checkbox"/> Residing in Community <input type="checkbox"/> Residing off Community

Suicide Risk: ☐ High ☐ Medium ☐ Low ☐ None ☐ Unknown

School Attending:

**Parent/Guardian/Emergency Contact Information:**

First Name:	Last Name:
Relationship to Child or Client:	
Street Address/Mailing Address:	Home Phone Number:
City and Province:	Cell Phone Number:
Postal Code:	Email:
First Name:	Last Name:
Relationship to Child or Client:	
Street Address/Mailing Address:	Home Phone Number:
City and Province:	Cell Phone Number:
Postal Code:	Email:

**Referral:**

Reason for Referral:

☐ *For physician/NP orders, you must attach script or instructions.*

**Referral Source:**

Referred by:	Relationship to client:
Agency/Organization:	Address:
Phone Number:	Email:

**Office use only:**

Referral received by:	Date:
Assigned to:	Manager's signature:
Entered into client database: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	