GIISHKAANDAGO'IKWE
HEALTH SERVICES

REFERRAL FORM

Date: _____
(DD/MM/YYYY)

CHILD'S FIRST INITIATIVE:

☐ Child's First Initiative (18 yrs. & under)
Fax: (807) 274 – 2528
Email: cfi.general@fftahs.org

MATERNAL CHILD HEALTH:

☐ Midwifery Program
☐ Milk Medicine
Fax: (807) 274 – 1064
Email: mch@fftahs.org

HOME & COMMUNITY CARE

☐ Home and Community Care
Fax: (807) 274 – 2050

☐ Foot Care & Diabetes
Fax: (807) 274 – 8725

PUBLIC HEALTH

☐ Community Health Nursing
☐ Environmental Public Health
☐ Children's Oral Health Initiative
Fax: (807) 274 – 8324

BEHAVIOURAL HEALTH SERVICES

☐ Mental Health Services
☐ Social Emergencies Services
Fax: (807) 274 – 1010
Email: mhsintake@fftahs.org
Mental Health Direct Line: (807) 271 – 0212
(during regular office hours - call or text)

MINO AYAA TAA WIN (MATW) HEALING CENTRE:

☐ Bed Based Treatment Program
☐ Mino Bimaadiziwin: Walking the Good Path (Pre-Treatment Program)
Fax: (855) 704 – 1591
Email: matwintake@fftahs.org

ADDICTIONS SERVICES:

☐ Community Addictions Services/Rapid Access Addiction Medicine (RAAM)
☐ Withdrawal Management
Fax: (807) 274 – 9941

Client Information:

Last Name:	First Name:
Preferred First Name:	Gender:
Date of Birth (DD/MM/YYYY):	Preferred Contact Number:
	Email:
Home Address:	Mailing Address:
City and Province:	City and Province:
Postal Code:	Postal Code:
Community: ☐ Residing in Community ☐ Residing off Community	
Suicide Risk: ☐ High ☐ Medium ☐ Low ☐ None ☐ Unknown	
If client has a substitute decision maker:	
Contact Name:	
Preferred Contact Number:	

If client is a child aged 0 – 18 years

Parent/Guardian/Support Staff Contact Information:	
First Name:	Last Name:
Relationship to Child or Client:	
Contact Number:	
Child In Care: ☐ Yes ☐ No	

Agency Name:

Referral:

Reason for Referral:

☐**For Physician/NP Orders, you must attach script or instructions**

Referral Source:

Referred by:	Relationship to client:
Physician/NP Signature:	Client aware of referral? ☐ Yes ☐ No
Agency/Organization:	
Phone Number:	Email:

Office use only:

Referral received by:	Date:
Assigned to:	Manager's signature:
Entered into client database: ☐ Yes ☐ No ☐ N/A	