GIISHKAANDAGO'IKWE
HEALTH SERVICES

REFERRAL FORM

Date: _____
(DD/MM/YYYY)

CHILDREN'S SERVICES & PUBLIC HEALTH

PUBLIC HEALTH:

☐ Community Health Nursing
☐ Environmental Public Health

For referrals for the above services:
Fax: (807) 274 – 8324

CHILD'S FIRST INITIATIVE:

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

For referrals for the above services:
Fax: (807) 274 – 2528

MATERNAL CHILD HEALTH:

☐ Children's Oral Health Initiative
☐ Indigenous Midwifery Program

For referrals for the above services:
Fax: (807) 274 – 1064

BEHAVIOURAL HEALTH SERVICES

☐ Mental Health Services
☐ Social Emergencies Services

For referrals for the above services:
Fax: (807) 274 – 1010
Email: bhsintake@fftahs.org
Mental Health Direct Line: (807) 271-0212
(during regular office hours - call or text)

☐ MATW Healing Centre
☐ Community Addictions Services

For referrals for the above services:
Fax: (807) 274 – 9941
Email: bhsintake@fftahs.org

HOME & COMMUNITY CARE

☐ Home and Community Care
For referrals for the above services:
Fax: (807) 274 – 2050

☐ Foot Care & Diabetes
For referrals for the above services:
Fax: (807) 274-8725

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	