



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
Email: cfi.general@fftahs.org

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: mhsintake@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: (855) 704-1591
Email: matwintake@fftahs.org

- Community Addictions Services

For referrals for the above services:
Fax: (807) 274 – 9941

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:	
<input type="checkbox"/> Residing in Community <input type="checkbox"/> Residing off Community	
Suicide Risk: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> None <input type="checkbox"/> 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:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Agency Name:	

Referral:

Reason for 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Agency/Organization:	
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	