NAAN•DOO•WE'AN

GARDEN RIVER WELLNESS CENTRE

JORDAN'S PRINCIPLE
GARDEN RIVER WELLNESS CENTRE • 23 SHINGWAUK STREET • GARDEN RIVER • ONTARIO • P6A 7B2
PH.705·946·5710 • FAX.705·946·2725 • INFO@GRHC.CA • WWW.GRWC.CA

REGISTRATION & PROFESSIONAL SERVICES REFERRAL FORM

Client Information			
Last Name:		First Name:	
D.O.B:		Sex:	
Daycare:		Address:	
School/Grade:		Community:	
Resides on Reserve: ☐ Yes ☐ No			
Status Card #:		Postal Code:	
Health Card #:		Agencies Involved:	
Client Physician:			
Is NOG Involved? ☐ Yes ☐ No		In NOG Custody? ☐ Yes ☐ No	
If Yes, Since When?			

Concerns/ Reasons for Referral
If necessary, please continue on back…

Parent/Guardian Information:			
First Name:		Agency Name (If applicable):	
Last Name:		Agency PH # (If applicable):	
Relation to client:		Home PH #:	
Legal Guardian: ☐ Yes ☐ No		Work PH #:	
Best Time to Call?		Cell PH #:	
Contact Restrictions?		Email Address:	
Consent obtained to share this referral information with the GR Education unit ☐ Yes ☐ No ☐ N/A			

INFORMATION: Who Requested This Referral?	
Individual/Agency Recommending Referral:	
Contact Information:	
Parent/Guardian Aware of this Referral/Registration?	☐ Yes ☐ No
Registration Method: ☐ Letter ☐ Fax ☐ Email Attachment ☐ PH Contact ☐ Office Visit	

OFFICE USE ONLY			
Form completed by:		Date:	

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CONSENT FOR THE RELEASE OF INFORMATION

Client's Name: D.O.B:

I, _____ **do hereby consent to the release of the following social,**
(Name of Client, Parent or Guardian)

academic and/or medical information of the aforementioned individual TO / FROM (circle T or F below)**:**

T / F ⇨ Huron Superior Catholic District School Board

T / F ⇨ Jordan's Principle

T / F ⇨ Garden River Wellness Centre

T / F ⇨

This information will be used for the following purpose(s):

⇨ Co-ordination of Service

⇨

I declare that my consent to the release of the information specified above has been given voluntarily, with the complete understanding that I may withdraw my consent at any time.

This consent for the release of the above-specified information is valid for one year from the date stated below, unless previously revoked by me. All information received will be kept confidential.

To maintain client confidentiality, please call the Garden River Wellness Centre (705-946-5710) prior to faxing this information. **If a charge is to be levied for the following requested information please notify the Garden River Wellness Centre prior to making any photocopies.**

_____ _____
Signature of Client, Parent or Guardian Date

_____ _____
Witness Signature and Title Date