Mushkegowuk Okimawiwin
Minopimatisiwinik Atoskawikamik
11 Elm Street N. Timmins, ON. P4N 6A3
Phone Number: 705-268-3594
Fax Number: 1-888-777-5708
Email: referral@mushkegowuk.ca

MUSHKEGOWUK OKIMAWIWIN MINOPIMATISIWINIK ATOSKAWIKAMIK

REFERRAL FORM

REFERRAL FORM

INTERNAL USE ONLY	
Received By:	
Date Received:	
Directed to:	
Date of Referral:	
CLIENT INFORMATION	
First Name:	Last Name:
Date of Birth:	Preferred Name:
Health Card Information: Health Card # _____ Version #: _____ Expiry Date: _____	
Address: _____ City: _____ Province: _____ Postal Code: _____ P.O Box # _____	
First Nation:	Status #:
Is there a need for an Interpreter? □ Yes □ No If Yes, specify which language _____ Are there accessibility concerns? □ Yes □ No If Yes, specify _____	

CLIENT CONTACT INFORMATION
By listing telephone numbers or an email address below, the referral source confirms that the person ("client") consents for Mushkegowuk Okimawiwin Minopimatisiwinik Atoskawikamik to call/email them regarding this referral. Mushkegowuk Okimawiwin Minopimatisiwinik Atoskawikamik will refrain from communicating unrequired personal information until consents are verified. **Client / Delegate Telephone Number(s)/E-mail Address** Contact information below is for: CLIENT/ DELEGATE *please circle* If Delegate, please specify relationship to client: _____ Phone # _____ Phone # _____ Email: _____

REFERRING PROVIDER INFORMATION	
First Name:	Last Name:

REFERRING PROVIDER ADDRESS

Address: _____ City: _____

Province: _____ Postal Code: _____ P.O Box #_____

Phone #	Fax#	Email:

Please select one of the following (what is your role in the person's wellbeing?):

□ Family Physician □ Nurse Practitioner □ Social Worker □ Suboxone/Methadone Provider

□ Child Welfare □ Mental Wellness □ Community Service Provider □ Traditional Healer □ Traditional Healer Program

□ Other (please specify): _____

REASON FOR REFERRAL	
Please indicate the primary reason for referral:	**Please select the service you're seeking for your client:** □ Primary Care □ Patient Advocacy/Patient Navigator □ Land Based Detox □ Mental Health and Wellness □ After-Care Services □ Relapse Prevention □ Firekeeper Program □ Support Services □ Traditional Healing and Wellness □ Traditional Healer

NOTES

RISK AND SAFETY CONCERNS			
This information is used to plan for the client's first appointment to ensure their safety and the safety of staff.			
RISK		**IF YES, WHEN?**	**DETAILS**
Suicide attempt / Ideation	□ Yes □ No		
Violent Behavior / Safety Concerns	□ Yes □ No		
Legal Involvement	□ Yes □ No		
Deliberate Self – Harm	□ Yes □ No		
Intervention Taken?	□ Yes □ No	Specify:	
Completed By:			
Signature:		**Date:**	