BIIGTIGONG MNO-ZHI-YAAWGAMIG

Striving Towards Holistic Health and Well-being

P.O Box 215
Heron Bay, Ontario P0T 1R0
Telephone: 807-229-1836
Fax: 807-229-3367

HEALTH SERVICES REFERRAL FORM

CLIENT INFORMATION

Legal First Name:	Last Name:
Preferred First Name:	Gender & Preferred Pronouns:
Anishinaabe Name:	Preferred phone number:
If client does not have a phone number consent to leaving non detailed message at: Name:	Phone #:
Date of Birth (YYYY/MM/DD):	Email:
Address (PO Box, Street, Community, Postal Code):	**Health Information** Health Card #: Status Card #:
Independence Level: ☐ dependent ☐ independent with assistance ☐ independent ☐ mobility restricted ☐ vision impaired ☐ speech impaired	
Risk: ☐ urgent ☐ ASAP ☐ non-urgent ☐ palliative	

PARENT/GUARDIAN/INFORMATION (if completing for child under 18 years)

Legal Guardian(s) Name:	Relationship to child:
Caregiver Contact Information	
First Name:	Last Name:
Address:	Phone #:
Relationship to Child:	

HEALTH SERVICES REQUESTED

Home and Community Care	Community Health	Diabetes Prevention	Other
☐ Nursing	☐ Immunization	☐ Foot care	☐ NIHB navigation
☐ Personal care	☐ Pre/postnatal	☐ Physical activity	☐ Children's Oral Health Initiative
☐ Homemaking	☐ Well-baby	☐ Food security	☐ Transportation
☐ Case management	☐ Breast-feeding support	☐ Other	☐ Traditional healing
☐ Respite Care	☐ Health teaching		
☐ Palliative Care	☐ Other		For full list of services visit: www.picriver.com/health
☐ Referral also sent to Home & Community Care Support Services NW			

Version: May 2025

REFERRAL

Primary Diagnosis:
Reason for Referral (*Please provide a brief description. If client consents, please also attach any relevant medical information, lab diagnostics, reports etc.*): ☐ **For physician/NP orders, written medical order(s) and best possible medication history must be attached.**
Allergies:
Suicide Risk: ☐ high ☐ medium ☐ low ☐ none ☐ unknown
Social determinants requiring assistance: ☐ housing ☐ unemployment ☐ education ☐ food in-security ☐ unknown ☐ other:

Date of Referral:	
Referred by:	Relationship to client:
Agency/Organization:	Address:
Phone Number:	Email:

OFFICE USE ONLY

Referral received by:	Date:
Assigned to:	Entered to cEMR: ☐ yes

Please fax referrals to 807-229-3367

Version: May 2025