



## Health Care Professional's Referral Form

**Fax to: 705-445-1516**

Admin: 705-444-0040 ext.249

**What to expect:** 211's Community Navigators help people understand community/government programs & services, assist with problem solving/decision making & connection to the most appropriate available services. Community Navigators may advocate for people at risk, conduct follow up to ensure continuity of care, and identify unmet needs/service gaps.

**Patient/Client Name:**

**Address:**

**No Fixed Address**

**Phone #:**

**Text Only**

**Or Email:**

**Name/Alternate Contact & Phone:**

**Health Link Patient**

**Home & Community Care (LHIN) Client**

**Other:**

**Health Card:**

**Health Card Version:**

**DOB (Y/M/D):**

**Identifies as:** Male Female Other

**Other patient demographics:**

Indigenous First Nation Metis Inuit

Francophone New Immigrant

**Other Language:** ~~AAA~~

**\*\*\*\*Doverty screening information:**

**Has difficulty making ends meet**

**Has not filed taxes**

**A detailed financial assessment has been  
conducted: Yes No**

**Client/patient agrees with this referral and consents to follow up by a 211 Community Navigator** Yes No

**Consent by Substitute Decision Maker** Yes No **Name/Relationship:**

**Indicate potential needs & note reason for referral:**

- ☐ Assistive devices (^È Èaids/ramps/CPAP)K
- ☐ Basic personal/household needs (^È Èdental/bed bugs):
- ☐ Community clinics (^È Èphysio/OT/rehab):
- ☐ Community supports (^È Èpain mgmt/smoking/peer groups):
- ☐ Falls prevention (^È Èclasses/education):
- ☐ Financial assistance (^È Èbills/budgeting/income):
- ☐ Food insecurity:
- ☐ Housing insecurity:
- ☐ Legal help:
- ☐ Mental health/addiction (^È Èfree clinics, private therapists/detox):
- ☐ Social isolation:
- ☐ Transportation:
- ☐ Other:

**Referring Source/Form Completed by:** Date:

Fax:

Physician/Staff Name:

Organization:

Phone #:

Email: