Fort Frances Tribal Area
HEALTH SERVICES

REFERRAL FORM

Date: _____

HEALTH SERVICES

- ☐ Home and Community Care (Nursing / Diabetes Ed. / Foot Care)
- ☐ Public/Community Health
- ☐ Child's First Initiative (18 yrs. & under)
- ☐ Children's Oral Health Initiative (0-7 yrs.)

For referrals for the above services:
Fax: (807) 274 – 2050

BEHAVIOURAL HEALTH SERVICES

- ☐ Mental Health and Counseling
- ☐ MATW Healing Centre (Treatment)
- ☐ Mental Wellness
- ☐ Brief Service
- ☐ Traditional Healing

For referrals for the above services:
Fax: (807) 274 – 3211

Client Information:

First Name:	Last Name:
Anishinaabe Name:	Clan:
Date of Birth (D/M/Y):	Sex: ☐ Male ☐ Undifferentiated ☐ Female ☐ Decline
Street Address/Mailing Address: City and Province: Postal Code:	Home Phone Number: Cell Phone Number: Email:
Health Card #: Status Card #:	Community: ☐ On reserve ☐ Off reserve
Suicide Risk: ☐ High ☐ Medium ☐ Low ☐ Not Applicable/No Risk	

Parent/Caregiver Information:

First Name:	Last Name:
Street Address/Mailing Address: City and Province: Postal Code:	Home Phone Number: Cell Phone Number: Email:

Referral:

Reason for Referral:
For physician/NP orders, please attach script or instructions.

Referral Source:

Referred by:	Relationship to client:

Office use only:

Referral received by:	Date:
Assigned to:	Supervisor signature:
Entered into client database: ☐ Yes ☐ No ☐ N/A	