



Date: _____
DD/MM/YYYY

Health Services

- Home and Community Care
(Nursing/Diabetes Education/Foot Care)
- Public/Community Health
- Child's First Initiative (18 years & under)

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

Behavioural health Services

- Mental Health & Counselling
- Crisis & Brief Services

For referrals for the above services:
Fax: (807) 274-1010
Email: bhsintake@fftahs.org

Client Information

First Name:	Last Name:
Anishinaabe Name:	Clan:
Date of Birth: (DD/MM/YYYY)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Two Spirited <input type="checkbox"/> Female <input type="checkbox"/> Decline
Street Address/Mailing Address:	Home Phone Number:
City and Province:	Cell Phone Number:
Postal Code:	Email:
Health Card #:	Community:
Status Card #:	<input type="checkbox"/> On Reserve <input type="checkbox"/> Off Reserve
Suicide Risk: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> Not Applicable/No Risk	

Parent/Caregiver Information

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

Reason for Referral

For physician/Nurse Practitioner orders, please attach script or instructions

Referral Source

Referred by:	Relationship to Client:
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Office use only

Referral Received by:	Date: (DD/MM/YYYY)
Assigned to:	Supervisors Signature:
Entered into client database: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	