

one-Link Referral Form: Fax to 905-338-2878

Inquiries: Toll Free: 1-844-216-7411

Website: www.one-Link.ca



Date of Referral:			
CLIENT INFORMATION		OHIP #	
Last Name:		First Name:	
Date of Birth (D/M/Y)		Gender:	
Street Address:		City:	Prov. Postal Code
Phone:		Can a message be left? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Alternate Contact Information:		Relationship:	
Name:			
Phone:			
Preferred Language:			
Is an interpreter requested? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Barriers to Communication:			
<input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Sight Impairment <input type="checkbox"/> Other			
Is this client being discharged from an Emergency Department? No <input type="checkbox"/> Yes <input type="checkbox"/>			
Specify hospital:			
Is this client being discharged from an Inpatient Unit? No <input type="checkbox"/> Yes <input type="checkbox"/>			
Specify hospital:			
<input type="checkbox"/> <i>Please check if limited consent was obtained, and some information was withheld by the client</i>			
Reason for Referral:			
Medications: list or attach all current medications:			
Is supportive housing requested? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Are Vocational Supports requested? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Referral Source Information: (affix sticker or stamp here)		Billing #:	
First & Last Name (print):			
Professional Designation:			
Office Address:			
Phone #:		Referring Physician Signature:	
Fax #		<i>(if applicable-required for NHMHC)</i>	

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