HealthLink / Maillonsanté
Champlain Region
Let's Make Healthy Change Happen / Favorisons la santé

Identification/Referral Form

Fax to: _____
Health Link: _____

Date of Referral: [Date] | Referral Source: _____ | Contact #: _____
Completed by: _____ | Title: _____ | Contact #: _____
Contact Email: _____
Health Link Care Coordinator (if assigned by your organization): _____

Patient Demographics

Health Card #: _____

Surname: _____ | Given name: _____

Address: _____ | City: _____ | Province: _____ | Postal Code: _____

Daytime Phone #:_____ | Alternate Phone #:_____

Date of Birth: _____ (*Format: DD / MM / YYYY*) | Gender: Male ☐ Female ☐ Undifferentiated ☐ Unknown ☐

Language of service: English ☐ French ☐ Other ☐ | Interpreter required: Yes ☐ No ☐

Primary Contact (if other than client): _____ | Relationship: Spouse ☐ POA ☐ Other ☐ _____
**this can be emergency contact*

Phone #: _____ | Alternate #: _____

Safety Precautions (e.g.: infectious disease, history of violence, pets etc.): _____

Primary Care & Reason for Referral

Primary Health Care Provider (e.g., MD or NP): _____ | Aware of Referral ☐

Contact Information (Phone & Fax#): _____

Reason for Referral (please be specific/expectations): _____

Health Link Criteria ☐ 4+ Chronic Conditions

☐Chronic Pain ☐Diabetes ☐Cancer
☐Palliative ☐Dementia ☐Frailty
☐Hypertension ☐ Neurological disorder ☐Arthritis
☐Pulmonary (COPD, asthma, emphysema)
☐Heart (CAD, CHF, MI, AF)
☐Mental Health (anxiety/mood disorders, schizophrenia, personality disorder)
☐Substance abuse
☐ Other (list all that apply): _____

☐ Other Considerations

☐Lives alone/Isolated
☐Lacks social supports
☐Risks for general safety
☐Abuse (past, present)
☐Frequent no shows
☐Frequent ED visits, Hospitalizations, Primary Care appointments, and use of services
☐Downward trajectory
Additional areas of Concern: _____

List Other Known Service Providers

1. _____ 3. _____
2. _____ 4. _____