Greater Sudbury Health Link Referral Form

This referral form will assist in identifying those who are appropriate for Greater Sudbury Health Link coordinated care planning.

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| --- | --- | --- | --- | --- |
| Demographic Information | | | | |
| Name: | | | | |
| Date of birth (dd/mm/yy): | | | | |
| Age: | | | Gender: | |
| Health Card Number: | | | No valid Health Card | |
| Address: | | | | |
| Phone: | | | | |
| Preferred method of contact: | | | | |
| Mother tongue: | Preferred official language: | | Ethnicity/Ancestry: | |
| Secondary contact name: | | | | |
| Relationship to individual: | | | Secondary contact phone: | |
| Referral Source | | | | |
| Name of agency/primary care provider: | | | | |
| Contact person: | | Phone: | | Fax: |
| ***Note to physicians and primary care providers:*** *Please provide the phone number where you can be most easily contacted by the Greater Sudbury Health Link Navigator.* | | | | |

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*Do not proceed with the collection of information without individual’s consent to proceed with a referral to the Greater Sudbury Health Link (see Documented Consent on page 3). If individual declines consent, please keep this document on your agency file for reference.*

**Greater Sudbury Health Links Target Population** Eligibility considerations include:

individuals with multiple chronic **and/or** complex conditions, including a focus on individuals living with mental illness, addictions, developmental disability, palliative patients, and the frail elderly. ***Check all that apply.***

|  |  |  |  |
| --- | --- | --- | --- |
| Eligibility Considerations – Check all that apply | | | |
|  | Mental illness (suspected or diagnosed)  *Describe*: |  | Frequent ED visits, hospitalizations, EMS calls and/or visits to primary care providers  *Describe*: |
|  | Substance addiction  *Describe*: |  | Cognitive challenges/decline; Acquired Brain Injury:  *Describe*: |
|  | Developmental disability  *Describe*: |  | Complex responsive behaviours that are impacting the individual’s health and well-being:  *Describe*: |
|  | Chronic disease, physical co-morbidities  *Describe*: |
|  | Social and/or economic stress factors:  *Describe*: |  | Palliative |

**Reason for Referral** (Please provide additional detail regarding your main concern, diagnoses, chronic disease condition, mental health condition, social risk factors, recent trigger/escalation):

**Other agencies/primary care provider/services involved** (if known)

**Other important information –** *please include* ***relevant******and current*** *legal and safety concerns* (strengths, historical information, etc.)

**Documented Consent**

|  |  |
| --- | --- |
| **The referred person consents to the following:** | **Yes/No** |
| Their personal health information being collected and stored by the North East LHIN – Home and Community Care |  |
| Their personal health information being stored by the Canadian Mental Health Association – Sudbury/Manitoulin as lead agency for the GSHL |  |
| Being contacted by the Greater Sudbury Health Link Navigator |  |
| A message being left for them by their Greater Sudbury Health Link Navigator |  |
| The Greater Sudbury Health Link Navigator contacting their identified secondary contact as needed/appropriate (in situations where the individual would like communication to be with another caregiver, family member etc. The secondary contact must be identified on page 1). |  |

I confirm that I have received the above verbal consents:

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Name of referring provider Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date