



REFUGEE HEALTH REFERRAL FORM

Refugee Health – Coordinated Access – Windsor Essex Community Health Centre (weCHC)

Please Fax Completed Form to: 226-216-5283

REFERRAL SOURCE:	
Referring Case Worker:	Date: yyyy-mmm-dd
Agency Name:	
Phone:	Fax:
CLIENT INFORMATION:	
Name: _____ Gender: _____	Personal Phone # _____
Arrival Date in Canada: yyyy-mmm-dd	Alternative Contact # _____
Country of Origin:	Can We Leave a Confidential Message: <input type="checkbox"/> Yes <input type="checkbox"/> No
Status in Canada:	Do You Have Transportation: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Birth:	Email Address: _____
Address / Are You Living with Family / Shelter Services:	Agencies Currently Connected to: _____
Health Card Number: _____ Version: _____	Have You Accessed Health Service in Windsor Previously: <input type="checkbox"/> Yes <input type="checkbox"/> No
Ontario Resident & Eligible for OHIP? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES – Where: _____
Spoken Languages:	Income / Drug Coverage (i.e. OHIP, IFH, No Coverage): _____
Language Level:	
Does a Family Member Interpret for You? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	Consent for Communication: Do You <input type="checkbox"/> Yes <input type="checkbox"/> No Consent to Multiple Agencies Being Involved in Your Treatment Journey?
Client Consents to This Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No	
HEALTH & SOCIAL INFORMATION:	
Primary Referral Reason:	Pre-Existing Medical Conditions / Food Allergies:
Are You Pregnant? Or Were You Pregnant Within the Previous 12 Months:	Current Pharmacy / Medication List:
Mental Health Diagnoses:	Safety Concerns / Suicide Assessment:
Referral Notes:	