

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-mm-dd
Agency Name:	
Phone:	Fax:
CLIENT INFORMATION:	
Name:	Gender:
Arrival Date in Canada: yyyy-mm-dd	Personal Phone #
Country of Origin:	Alternative Contact #
Status in Canada:	Can We Leave a Confidential Message: ☐ Yes ☐ No
Date of Birth:	Do You Have Transportation: ☐ Yes ☐ No
Address / Are You Living with Family / Shelter Services:	Email Address:
	Agencies Currently Connected to:
Health Card Number:	Version:
Ontario Resident & Eligible for OHIP? ☐ Yes ☐ No	Have You Accessed Health Service in Windsor Previously: ☐ Yes ☐ No
Spoken Languages:	If YES – Where:
Language Level:	Income / Drug Coverage (i.e. OHIP, IFH, No Coverage):
Does a Family Member Interpret for You? ☐ Yes ☐ No	
Interpreter Required: ☐ Yes ☐ No	Consent for Communication: Do You ☐ Yes ☐ No
Client Consents to This Referral: ☐ Yes ☐ No	Consent to Multiple Agencies Being Involved in Your Treatment Journey?
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:	