Dilico
Anishinabek Family Care

Place Label Here if Applicable

REFERRAL – HEALTH SERVICES

Purpose: To obtain information about a client/family being referred to District or In City Health Services.
Instructions: 1) Provide as much information as possible. 2) Discharge orders, care plans and other relevant documents must be included/attached. 3) Send completed form to healthreferrals@dilico.com.

☐ **Client agreeable to Dilico Health Services**
☐ **Client consents to the release/disclosure of prior medical records for medical purposes**

Referral Source Information	
Referent:	Agency:
Email:	Telephone:

Services Required	
☐ Addictions	☐ Medication Review
☐ Counseling	☐ Midwifery
☐ Cultural Services	☐ Occupational Therapy
☐ Diabetes	☐ Parenting Support
☐ Education:	☐ Personal Care (Support at Home)
☐ Foot Care	☐ Physiotherapy
☐ Health Inspection (Housing)	☐ Require Family Doctor/Nurse Practitioner
☐ Healthy Eating/Nutrition	☐ Social Services Navigation
☐ Hospital Discharge (MD/NP Orders Required)	☐ Sexual Education
☐ Immunizations/Vaccinations	☐ Speech-Language Pathology
☐ Infant and Child Wellness (Growth Development)	☐ Traditional Healing
☐ Jordan's Principle Application (Under 18)	☐ Tragic and Crisis Response
☐ Lice/Mites/Ticks/Bed Bugs/Scabies	☐ Wellness Check
☐ Life Skills Training	☐ Wound Care
☐ Medication Monitoring	

MD/NP Orders / Care Plan	
Referring Party Name:	Date:
Signature:	

Comment Section

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Identified Client Information			
First Name:		Street Address:	
Middle Name:		Mailing Address:	
Last Name:		City:	
Other Names:		Province:	Postal Code:
DOB:		Home Phone:	
☐ Female	☐ Male ☐ Other	Cell Phone:	
Service Language:		Other Phone:	
Health Card:		Status Card:	
First Nation:		Lives on Reserve: ☐ Yes ☐ No	
Primary Health Care Provider			
Full Name:		Office Phone:	

Identified Medical Condition(s)	List of Medications

Allergies: ☐ Yes ☐ No
If yes, please list:

Primary Caregiver Information		
Caregiver/Parent/Guardian Name:		Relationship:
Home Phone:	Cell Phone:	
Address *(if different from client)*:		