Niagara Medical Group Family Health Team – Community Health Prosperity Program

Referring Health Service Provider (or stamp)	**Referral Date**:mm/dd/yyyy
Name:_______________ Organization Name: ___________ Phone #: ___________ Fax #:___________ Signature:___________	☐ Direct Referral – NMGFHT FAX:905-356-2765 Translation Required? ☐Yes ☐No

Family Physician/Most Responsible Provider (if available)

Name:_______________ Organization Name: _______________

Address: _______________

Phone #: ___________ Fax #:___________

Patient Information

Name: _______________ Gender:___________ DOB: ___________

Address:_______________

City: ___________ Postal Code: ___________ Health Card #: ___________

Contact Number:___________ Alternate Contact: ___________

___________ Preferred Language of Service: ___________

☐ HealthLinks Identified Patient ICL:___________

Reason for Referral:

☐Social Needs Assessment (Please provide detail in reason):

Identified Social Need(s):

☐Housing ☐ Food Security ☐Transportation ☐ Employment Resources ☐Family Supports

☐ Financial: ☐ Financial Literacy ☐ Budgeting ☐ Income Tax Clinic

Relevant Medical History – Please fill out or attach CPP if available

Medications:	Please attach most recent medication list.

For Internal Use Only – Date Received at NMGFHT: ___________