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: _____