Date of Referral:
_____/_____/_____

HealthLink
Haldimand HealthLink
Let's Make Healthy Change Happen

Haldimand War Memorial Hospital

Phone 905.229.2261 | Fax 905.774.6776

Referral Information

Name:	**Date of Birth:**
Telephone Number:	**Health Card Number:**

Contact Number to Arrange Visit:

☐ as above, or

Alternative Contact: (name, telephone, relationship)

_____

_____

Referred By:

☐ **Primary Care**	☐ **Community Agency**	☐ **Self**	☐ **Other**

Name of Primary Care or Agency: _____

Contact Person: _____ **Telephone:** _____ **Fax:** _____

Health Profile (check all applicable):

☐ COPD	☐ Other respiratory	☐ CHF	☐ Falls
☐ Complex Diabetes	☐ Medication Education	☐ Mental Health Concerns	☐ Housing
☐ Caregiver Burden	☐ Social Isolation	☐ Poverty	☐ Addictions

Additional information (current concerns, history, treatment, medications, etc)

(Attach documents if necessary)

Do you feel that the referred person would benefit from a coordinated care plan: ☐ yes ☐ no

Referred Person consents to being contacted by a team member: ☐ yes ☐ no

Referred person consents to a message being left for them from the Health Link Team: ☐ yes ☐