Request For Services - External

Elsipogtog Health & Wellness Centre

Phone: 506.523.8227 Fax: 506.523.4685

Medicare # : _____ **Band #:** _____

Last Name: _____ **D.O.B:** ____ - ____ - _____
DD MM YYYY

First Name: _____

Address: _____ **M** ☐ **F** ☐

Home Phone: _____ **Work Phone:** _____

Next of kin: _____ **Tel #:** _____

Service Requested:

☐ Health/Clinic Doctor, Nurse, Dietician, LPN, Traditional, Eastern Door) ☐ Eastern Door Prog.

☐ Mental Health (Psychologist, Alcohol & Drug, Crisis, Parenting) ☐ Headstart/Outreach

☐ Home & Community Care (Post hospital discharge, Homemaking, Personal Care)

☐ Public Health (Maternal-Child, Immunization, Communicable Disease, Environment)

☐ Restorative Justice (Victim's Assistance) ☐ other _____

Reason for referral and expectations:

_____

_____

_____

_____

Referred by: _____ **Contact Person:** _____

Address: _____ **Phone:** _____

_____

Client consent to release health information relevant to the referral

Client Signature: **Date:** _____

Degree of Urgency: Immediate ☐ Soon ☐ Planned ☐

For Office Use Only

Request received by: _____ **Date:** _____

Comments: _____

_____

Feedback to referral source: ☐ eligible for services ☐ not eligible for services

☐ Admitted and will receive services starting _____

☐ Referred to another service, specify: _____

☐ Other comments _____