FAX TO: 613-283-0523
For Information Call: 613-283-0001

South East LHIN Health Link Referral

Referred by:

Referral Source and Date: (please print) ____

Phone Number: _________________________________ Fax: ____________________________

Individual Information:

Name of Individual: ___________________________________ Phone #: __________________

Gender: ____________ DOB: _________________ Health Card #: _________________________

Address: ____

City: _______________________________________ Postal Code: ______________________

Alternate contact: ___________________________ Phone Number: _______________________

Primary Care Provider: __________________________ Phone Number: ___________________

Health Link Criteria

1. 4+ Chronic Conditions including:

__Mental Health	__ HIV/AIDS	__ Frailty	__Dementia
__ Chronic Pain	__ Palliative	__ Diabetes	__ Cancer
__ Arthritis/related disorders	__ Hypertension	__ Heart Disease	__ COPD
__ Neurological Disorders	__ Lung Disease	__ Liver Disease	__ Addictions
__ Developmental Disability	__ Amputations	__ Kidney Disease	

Other (List all that apply):

____

2. Challenge(s) with social determinants of health:

__ Low income   __ Housing   __ Social Isolation   __ Food Insecurity   __ Transportation

3. Clinical Judgement (If fewer than 4 Chronic Conditions):

This individual would benefit from Health Links approach to care coordination: **Yes ___ No ___**

Additional Information

Current Community Support Services (Including Palliative Care Services):

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Individual aware of referral: Yes___ No___

Relevant Information Attached (medical history, etc.): Yes___ No ___