CONFIDENTIAL REFERRAL FORM

Community Care North Hastings, Bancroft

REFERRAL TO:

_____

CLIENT NAME:_____ **DATE:**____/____/____
mm dd yy

ADDRESS:_____

CIVIC (911) ADDRESS:_____

POSTAL CODE:_____ **TELEPHONE:**_____

HEALTH CARD NUMBER:_____

SEX: Male ☐ **Female** ☐ **DATE OF BIRTH:** ____/____/____
mm dd yy

Reason for referral:

_____

Services requested:

_____

_____

Alternate contact person's name & phone number:

_____

Access Centre services that this client is currently receiving:

_____

The client named above has agreed to this referral ☐ **YES (please check if client has agreed)**

Access Centre case manager name & contact info:

_____

Complete this form and mail or fax it to Community Care North Hastings, PO Box 1786, Bancroft, ON K0L 1C0; FAX 613 332-0432.

Revised 13/01/06