HealthLink

MICs Health Link

Let's Make Healthy Change Happen

Fax completed referrals to the Health Link Program Coordinator at: (705) 258-2828

MICs Health Link Referral Form

This referral form will assist in identifying those who are appropriate for MICs Health Link coordinated care planning.

Demographic Information		
Name:		
Date of birth (dd/mm/yy):		
Age:		Gender:
Health Card Number:		No valid Health Card☐
Address:		
Phone:		
Preferred method of contact:		
Mother tongue:	Preferred official language:	Ethnicity/Ancestry:
Secondary contact name:		
Relationship to individual:		Secondary contact phone:

Referral Source		
Name of agency/primary care provider:		
Contact person:	Phone:	Fax:
Will you be completing the CCP?	Yes	No
If you are completing CCP please identify who the Care Coordinator will be.	Care Coordinator:	Contact #:

Note to physicians and primary care providers: *Please provide the phone number where you can be most easily contacted by the MICs Health Link Program Coordinator.*

Also, please note that as the Primary Care Provider upon referral this client/patient will meet with the HL Care Coordinator and a Coordinated Care Plan will be developed; and that I as the PCP will be involved in that plan.

Adapted from the Greater Sudbury Health Link
November 2017

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Do not proceed with the collection of information without individual's verbal consent to proceed with a referral to the MICs Health Link. If individual declines consent, please keep this document on your agency file for reference.

Reason for Referral (Please provide additional detail regarding your main concern, diagnoses, chronic disease condition, mental health condition, social risk factors, recent trigger/escalation):

Other agencies/primary care provider/services involved (if known)

Other important information – *please include* ***relevant and current*** *legal and safety concerns* (strengths, historical information, etc.)

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Documented Consent

The referred person consents to the following:	Yes/No
Their personal health information being collected and stored at the Agency's involved in their Coordinated Care Plan.	
Their personal health information being stored at the Iroquois Falls Family Health Team by the Program Coordinator as the lead agency for the MICs Health Link.	
Being contacted by a MICs Health Link Care Coordinator	
A message being left for them by their MICs Health Link Care Coordinator	
The MICs Health Link Care Coordinator may be contacting their identified secondary contact as needed/appropriate (in situations where the individual would like communication to be with another caregiver, family member etc. The secondary contact must be identified on page 1).	

I confirm that I have received the above verbal consents:

_____ _____

Name of referring provider Signature

_____

Date