

one-Link Referral Form: Fax to 905-338-2878

Inquiries: Toll Free: 1-844-216-7411

Website: www.one-Link.ca



Date of Referral:	
CLIENT INFORMATION	OHIP #
Last Name:	First Name:
Date of Birth (D/M/Y)	Gender:
Street Address:	City: Prov. Postal Code
Phone:	Can a message be left? <input type="checkbox"/> Yes <input type="checkbox"/> No
Alternate Contact Information: Name:	Relationship:
Phone:	
Preferred Language:	
Is an interpreter requested? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Barriers to Communication: <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Sight Impairment <input type="checkbox"/> Other	
Is this client being discharged from an Emergency Department ? No <input type="checkbox"/> Yes <input type="checkbox"/> Specify hospital:	
Is this client being discharged from an Inpatient Unit? No <input type="checkbox"/> Yes <input type="checkbox"/> Specify hospital:	
<input type="checkbox"/> <i>Please check if limited consent was obtained, and some information was withheld by the client</i>	
Reason for Referral:	
Medications: list or attach all current medications:	
Is supportive housing requested? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Are Vocational Supports requested? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Referral Source Information: (affix sticker or stamp here) First & Last Name (print): Professional Designation: Office Address: Phone #: Fax #	Billing #:

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