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

Inquiries: Toll Free: 1-844-216-7411
Website: www.one-Link.ca

one-Link
Connecting you to addictions and mental health services

Halton Healthcare
GEORGETOWN · MILTON · OAKVILLE

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?** ☐ **Yes** ☐ **No**
Alternate Contact Information: **Relationship:** **Name:** **Phone:**	
Preferred Language:	
Is an interpreter requested? ☐ **No** ☐ **Yes**	
Barriers to Communication: ☐ **Cognitive Impairment** ☐ **Hearing Impaired** ☐ **Sight Impairment** ☐ **Other**	
Is this client being discharged from an Emergency Department ? **No** ☐ **Yes** ☐ **Specify hospital:**	
Is this client being discharged from an Inpatient Unit? **No** ☐ **Yes** ☐ **Specify hospital:**	
☐ *Please check if limited consent was obtained, and some information was withheld by the client*	
Reason for Referral:	
Medications: list or attach all current medications:	
Is supportive housing requested? ☐ **No** ☐ **Yes**	
Are Vocational Supports requested? ☐ **No** ☐ **Yes**	
Referral Source Information: (affix sticker or stamp here) **Billing #:** **First & Last Name (print):** **Professional Designation:** **Office Address:** **Phone #:** **Fax #**	