ACCESS LINE REFERRAL & CONSENT FORM

Please complete and return this form by fax to 905-682-7959

Patient Label
Health Care Provider Stamp/Label

PATIENT INFORMATION		
Date of referral: **First Name:**	**Health Card Number:** **Last Name:**	
Date of Birth (mm/dd/yyyy):	**Gender:** ☐ Male ☐ Female **Other:**	
	Pronoun preferred:	
Street Address:	**City:**	**Postal Code**
Phone (home):	**Can a message be left?** ☐ **Yes** ☐ **No**	
Phone (cell):	**Can a message be left?** ☐ **Yes** ☐ **No**	

Alternate Contact Information (if any):	
Name:	**Relationship:**
Phone:	

Preferred Language	☐ **English**	☐ **French**	**Other:**
Is an interpreter requested?	☐ **Yes**	☐ **No**	
Barriers to Communication:			
☐ Cognitive Impairment			
☐ Hearing Impaired			
☐ Sight Impairment			
☐ Other (please describe):			
Reason for Referral:			
Medications (list or attach all current medications):			
Supportive housing requested?	☐ **Yes**	☐ **No**	
Additional Comments:			

HEALTHCARE PROVIDER INFORMATION	
Fill out if details are not included in stamp/label above	
Name:	**Discipline:**
Phone:	**Fax:**
Email:	

CONSENT

- ☐ I agree to receive fax and/or email communication about this referral from XXX
- ☐ Patient has verbally consented to the disclosure of their personal health information for the purpose of a referral to Mental Health and Addictions Access Line
- ☐ Patient has verbally consented to an access line community worker calling them for the purpose of coordinating referrals to appropriate health and/or addictions services