REFERRAL FORM
Couching OHT Care Clinic

For individuals without a primary care provider
Phone: 705-325-2201 ext. 8250 - Fax:705-325-4171
Email: cohtcareclinic@osmh.on.ca

This is a temporary service. **ALL** patients **MUST** register with Health Care Connect to obtain a permanent Primary Health Care Provider. Patients are permitted to self-refer.

*NO Narcotics will be prescribed!

Registered with Health811: YES ☐ NO ☐

Health811 can be reached by calling 811 or 1-866-797-0007 or online at Ontario.ca/health811

Legal Name: Preferred Name:

Gender Identity: Sex Assigned at Birth:

Date of Birth: dd/mm/yyyy ____/____/_______

Address:

Phone: __ __ __ - __ __ __ - __ __ __ __

May we leave messages on patient's phone? YES ☐ NO ☐

Emergency Contact:

Name: Relationship: Phone:

Health Card Number: __ __ __ __ __ __ __ __ __ __ Version Code: __ __

Date of Expiry dd/mm/yyyy ____/____/_______

Preferred Pharmacy: Phone Number:

Allergies (medications/food/environmental):

Current Health Concerns (Please List):

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Medications:
Medical History:
Surgical History:
Mental Health History:
Drug/Alcohol Use:
Date of Referral:
Patient Signature:
Referral Source:
Where would you have sought care today if this clinic was not available to you:

**** Please fax referral form with any pertinent documentation to 705-325-4171 ****