REFERRAL FORM
Couchiching 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

The COHT Care Clinic provides episodic access to interim primary care. ALL patients MUST register with Health Care Connect to obtain a permanent Primary Health Care Provider. Patients are permitted to self refer.
This clinic is unable to prescribe narcotics.

Registered with Health Care Connect: ☐ YES ☐ NO

Patients can call: 1-800-445-1822 or go online | Alternate option include Health 8-1-1

Referral to Nurse Practitioner: ☐

Referral to Social Worker: ☐

Legal Name: [Last, First] 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):

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Current Health Concerns (Please List):
Medications:
Medical History:
Surgical History:
Mental Health History:
Drug/Alcohol Use:
Date of Referral: dd/mm/yyyy ____/____/_____
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 ****