421 Shepherdson Road
New Liskeard, ONP0J 1P0
Phone: 1-855-647-7874
Fax: 1-833-734-7361

Mino M'shki-ki
Indigenous Health Team

New Patient Referral Form

In keeping with confidentiality guidelines, referrals are only permitted with the consent of the person.

Please complete both pages and send to Christine Julien, Medical Secretary/Administrative Assistant by email healthteam@minomshkiki.ca or fax 1-833-734-7361.

Once referral is received an intake appointment will be scheduled.

Name: _____ Date of Birth: _____

Address: _____

Health Card Number & Version Code: _____

Sex: ☐Male ☐Female ☐Prefer not to say ☐Other _____

If this member is a child, please provide name of parent(s)/legal guardian(s)

Name: _____

Contact Information:

Phone# (preferred) _____ Can a message be left at this number? ☐Yes ☐ No

If the member does not have access to a phone, please provide alternate contact method (ex. email address) or an alternate contact name and phone number

Alternate contact method: _____

Contact Person: _____ Phone#: _____

Can a message be left at this number? ☐Yes ☐ No

Current Pharmacy: _____

Current Doctor/Nurse Practitioner: _____

Purpose of the referral:

Which services are they looking to receive? (Primary Care Provider i.e. Doctor or Nurse Practitioner, Counselling Services, Foot Care, Reflexology, other). Specific concerns?

In signing this form, I agree that I have spoken to and received consent from the person being referred to share their information with Mino M'shki-ki Indigenous Health Team.

Person completing the referral (Print Name): _____

Phone# _____

Signature: _____