Erie St. Clair
Regional Cancer Program
Ontario Health (Cancer Care Ontario)

INDIGENOUS PATIENT REFERRAL FORM

All information MUST be complete for the referral to be processed.
Incomplete or unsigned referrals will be returned for completion.

PATIENT INFORMATION (Please Print)

Surname		**Given Name(s)**
Date of Birth _____ / _____ / _____ *dd* *mm* *yy*	**Gender** □ Male □ Female	**OHIP # (Include Version Code)**
Address		**City/Province** / **Postal Code**
Patient's Contact Information **Home** _____ **Work** _____ **Cell** _____		**Contact Person** **Name** _____ **Relationship** _____ **Home** _____ **Work** _____ **Cell** _____

CLINICAL INFORMATION

Other support agencies: _____ _____ **Location:** _____ _____ **Family Doctor:** _____ **Telephone:** _____ **Date of Interaction:** _____ **Method of Interaction:** _____	**Patient Informed of reason for Referral?** □ Yes □ No **Date patient was informed:** _____ *Note: Patient **must** be informed of referral reason*	**Reason for Referral** □ Support Program □ Educational Program □ Diversional Program □ Volunteer Services □ Complementary Services

WINDSOR REGIONAL HOSPITAL – CANCER PROGRAM USAGE ONLY

Next of Kin
Name _____ **Relationship** _____
Address _____ **Postal Code** _____
Telephone (H) _____ **(W)** _____ **(C)** _____

Family/Significant Others

Name	Relationship	Phone Number

Fax completed forms to (519)255-8670
ATTENTION: ARLENE KING, INDIGENOUS PATIENT NAVIGATOR