one-Link Referral Form: Fax to 905-338-2878

Inquiries: Toll Free: 1-844-216-7411
Website: www.one-Link.ca

Date of Referral:

CLIENT INFORMATION	**OHIP #**
Last Name:	**First Name:**
Date of Birth (D/M/Y)	**Gender:**
Street Address:	**City:** **Prov.** **Postal Code**
Phone:	**Can a message be left?** ☐ **Yes** ☐ **No**
Alternate Contact Information: **Relationship:** **Name:** **Phone:**	
Preferred Language:	
Is an interpreter requested? ☐ **No** ☐ **Yes**	
Barriers to Communication: ☐ **Cognitive Impairment** ☐ **Hearing Impaired** ☐ **Sight Impairment** ☐ **Other**	
Is this client being discharged from an Emergency Department? **No** ☐ **Yes** ☐ **Specify hospital:**	
Is this client being discharged from an Inpatient Unit? **No** ☐ **Yes** ☐ **Specify hospital:**	
Please check if limited consent was obtained, and some information was withheld by the client	
Reason for Referral:	
Medications: list or attach all current medications:	
Is supportive housing requested? ☐ **No** ☐ **Yes**	
Are Employment Supports requested? ☐ **No** ☐ **Yes**	
Referral Source Information: (affix sticker or stamp here) **Billing #:** **First & Last Name (print):** **Professional Designation:** **Office Address:** **Phone #:** **Fax #**	

Before faxing clinical information, please ensure fax number (905-338-2878) is automatically programmed into your equipment. This facsimile transmission is confidential, may contain legally privileged information and is intended for the review by only the individual or party to whom it is addressed, and for no one else. If it is received by someone other than the intended recipient, any dissemination, distribution or copy of this facsimile transmission is strictly prohibited. Please notify us immediately by phone and return the facsimile transmission to us by mail. One-Link is complaint with current privacy legislation. One-Link collects personal information for clinical service coordination assessment and treatment, research, and legal and regulatory purposes. **Form updated: August 2017**