

SIX NATIONS HEALTH SERVICES (SNHS) INTERNAL MEDICINE RAPID ASSESSMENT CLINIC (IMRAC)
 1769 Chiefswood Rd, Ohsweken ON N0A 1M0 Telephone: 519-445-2251 Fax: 519-445-4679

Patient Demographics

Phone Number

Last Name	First Name	Please enter a valid contact number	
Address			Date of Birth
Street	City	Province	Postal Code
Health Card Number	Email Address		Consent to use of Email
			Yes <input type="checkbox"/> No <input type="checkbox"/>
10-digit number	Version Code		
Next of Kin (Emergency Contact)		Phone number	

Last Name	First Name	Please enter a valid contact number	
Does Patient identify as			
<input type="checkbox"/> First Nation	<input type="checkbox"/> Inuit.	<input type="checkbox"/> Métis	

Referral Information

Date of Referral	Referring Physician/NP/HCW Please provide designation if not MD/NP	Phone Number	Fax Number
Referral Source (if applicable)			

<input type="checkbox"/> Six Nations FHT	<input type="checkbox"/> BGH ER	<input type="checkbox"/> Community Paramedicine
<input type="checkbox"/> Primary Care Provider – outside Six Nations	<input type="checkbox"/> Public Health	<input type="checkbox"/> St. Joseph’s Hospital - ER
<input type="checkbox"/> Community Health Teams/Case Managers/Social Worker	<input type="checkbox"/> Other	

Please indicate urgency of referral. If patient needs to be seen within less 48 hours-please contact the office and the internist on call for the week will call you to review/assess patient.

<input type="checkbox"/> Urgent (Within 2-5 days)	<input type="checkbox"/> Semi-Urgent (within 1-2 weeks)	<input type="checkbox"/> Routine (within 3-4 weeks)
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Please note that patient will be triaged and the urgency status may change.

Reason for Referral

Relevant PMHx, Medications, Medical Investigations-please indicate if information is available on Clinical Connect

Please indicate if patient requires any kind of assistance (check all that apply)

<input type="checkbox"/> Cognitive Impairment	<input type="checkbox"/> Mental Health History	<input type="checkbox"/> Mobility Issues	<input type="checkbox"/> Hearing Impairment
<input type="checkbox"/> Vision Impairment	<input type="checkbox"/> Translator Required (please indicate language):		
<input type="checkbox"/> Other			

Referring Physician/NP/HCP’s Signature
 HCP=HealthCare Provider

Billing Number (If applicable)