Allied Health Care Support Referral Form for Providers

Grand River Community Health Centre
363 Colborne St, Brantford, ON, N3S 3N2
177 Colborne St W, Brantford, ON, N3T 1L3
Phone: 519754-0777 ext 233 Fax: 519-754-0757

Provider information

Name _____ Date (mm/dd/yyyy) _____
Organization Name _____
Phone _____ Fax _____

Client information

Name _____ Date of birth (mm/dd/yyyy) _____
Address _____City _____
Postal Code _____Health Card _____
Phone _____Email_____
Client pronouns are: ☐ She/Her ☐ He/Him ☐ They/Them

Please check off the primary reason for the referral:

Individual support:

- ☐ Nutrition counselling (Care provided by Registered Dietitians) – Nutrition education for clients across the human lifespan and goal setting to improve health
- ☐ Mental health counselling – Supporting individuals with developing positive coping strategies and achieving overall mental wellness
- ☐ Social prescribing and Navigation – Assisting clients with connecting to non-clinical resources and services to improve social connection and well-being
- ☐ Smoking Cessation – Stop Program – a program that supports clients to quit smoking. Nurse led.

Reason for referral: _____

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Please attach any relevant health information, including medical history, medications, and lab work.

Please Fax referral to 519-754-0757 Attn: IPCT Program