

**Mamaway Wiidokdaadwin  
Indigenous Interprofessional  
Primary Care Team**

**REFERRAL CONSENT FORM**

Barrie Fax #: 705-721-3955

Orillia Fax #: 705-259-2010

I, \_\_\_\_\_,  
(Print your name, or your name and relationship if you are a Parent/Guardian or Substitute Decision Maker)

For \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Self or Name of Person) (dd/mm/yyyy)

Current Primary Care Provider: \_\_\_\_\_

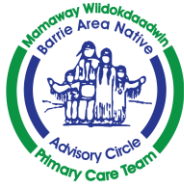
**consent to a referral to Mamaway Wiidokdaadwin Primary Care Team for the following service(s) (check all that apply and CIRCLE the location of the requested service):**

- |   |         |        |              |            |
|---|---------|--------|--------------|------------|
| <input type="checkbox"/> Primary Care         | Orillia | Barrie | Rama         | Beausoleil |
| <input type="checkbox"/> Traditional Healing  | Orillia | Barrie | Rama         | Beausoleil |
| <input type="checkbox"/> Counselling Services | Orillia | Barrie | Rama         | Beausoleil |
| <input type="checkbox"/> Health Promotion     | Orillia | Barrie | Other: _____ |            |

as discussed with \_\_\_\_\_  
(Name of Service Provider and Organization)

1) Please share your Indigenous identity and your community/nation, if known, so we are better able to service you:

- First Nations Nation/Community: \_\_\_\_\_  
Do you have a Status Card? Y/N
- Métis Community: \_\_\_\_\_
- Inuit Community: \_\_\_\_\_



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2) If referring for primary care, your medical needs will be assessed during your intake appointment. If you are referring for Counselling or Traditional Healing, please share, if able, the potential target of services: \_\_\_\_\_

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(examples include but not limited to: counselling or ceremony to support coping grief, anxiety/depression or other mental health diagnoses, family/couple counselling, traditional counselling, addiction or substance misuse, coping with trauma, managing physical and/or emotional pain)

**DECLARATION OF INFORMED CONSENT:**

**I understand that identifying information, including my contact information may be shared for the purpose of completing this referral. I also understand that this referral is voluntary, and consent can be revoked at any time.**

Preferred Method of Contact for person seeking service (check all that apply):

- Home Phone: \_\_\_\_\_ Voicemail? Y/N  
 Mobile Phone: \_\_\_\_\_ Voicemail? Y/N Text? Y/N  
 Contact Referral Source: \_\_\_\_\_ Ext: \_\_\_\_\_

\_\_\_\_\_  
Signature of Individual, Parent(s), Guardian(s),  
or Substitute Decision Maker

\_\_\_\_\_  
Date (dd/mm/yyyy)

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date (dd/mm/yyyy)