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):

☐	Primary Care	Orillia	Barrie	Rama	Beausoleil
☐	Traditional Healing	Orillia	Barrie	Rama	Beausoleil
☐	Counselling Services	Orillia	Barrie	Rama	Beausoleil
☐	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: _____

_____

_____

(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)