



**Mamaway Wiidokdaadwin
Indigenous Interprofessional
Primary Care Team**

REFERRAL CONSENT FORM

Barrie Fax # 855-941-2529
Orillia Fax # 855-941-2531

www.mamaway.ca



What is this form about?

We must get your permission to share your information with other services at Mamaway Wiidokdaadwin. By signing this form, you are allowing us to share your information with the services listed below. Sharing your information will help us connect you with services that will be helpful for you. Giving your information to a service is called a **referral**. Giving your permission is also known as giving **consent**.

REFERRAL CONSENT FORM

Name: _____

Date of Birth: _____
DD/MM/YYYY

Current Primary Care Provider: _____

Community Supports: _____

I, _____ consent to a referral to Mamaway Wiidokdaadwin Primary Care Team for the following service(s):

- | | |
|--|--|
| <input type="checkbox"/> Primary Care | <input type="checkbox"/> Mental Health and Addictions Indigenous Patient Navigator |
| <input type="checkbox"/> Health Promotion | <input type="checkbox"/> Opioid Outreach (Barrie Only) |
| <input type="checkbox"/> Gathering Our Bundles | <input type="checkbox"/> Traditional Healing - provide your email below |
| <input type="checkbox"/> Red Road to Recovery | |
| <input type="checkbox"/> Mobile Withdrawal Service | Other (please list): _____ |
| <input type="checkbox"/> Horse Assisted Wellness | |

- Ontario Structured Psychotherapy through Waypoint Centre for Mental Health
You can self-refer to this program. This means that you can call to access the program yourself and don't need a health care provider to make the referral on your behalf. You can self-refer:
- **Online:** <https://osp-nsm.portal.gs/accounts/patient/referral/>
 - **By phone:** 1-877—341-4729 ext. 2883

I discussed this referral with _____

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

- | | |
|--|----------------------------------|
| <input type="checkbox"/> First Nations
Do you have a Status Card? | Nation/Community: _____
Y / N |
| <input type="checkbox"/> Métis | Community: _____ |
| <input type="checkbox"/> Inuit | Community: _____ |

Referrals to Primary Care:

If this referral is for primary care, your medical needs will be assessed by a health care provider during your intake appointment.

Referrals to Other Programs and Services Listed:

If you are seeking a referral to other programs listed, please tell us more about your needs (check all that apply)

- Seeking ceremony for specific purpose (list below)
- Learning more about your culture/nation
- Building community through Mamaway workshops and events (list email below)
- Learning culturally relevant coping skills and healing practices
- Seeking Elder services for teachings or ceremony
- Support with grief and loss
- Learning cultural approaches to healthy living (nutrition and/or lifestyle)
- Support with mental health diagnosis or symptoms (list below)
- Maintaining or beginning addictions recovery
- Healing from trauma
- Managing physical and/or emotional pain

More information:

If you would like to be added to our mailing list for upcoming workshops, community events and more, please check and leave your email address:

I would like to receive Mamaway event and workshop emails: _____

Declaration of Informed Consent:

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

Preferred method of contact for person seeking service (check all that apply):

- Home Phone: _____ Can we leave a voicemail? Y / N
- Mobile Phone: _____ Can we leave a voicemail? Y / N
- Organization Phone: _____ Can we text you here? Y / N
- Extension # _____

Address:

Signature of Individual, Parent, Guardian or Substitute Decision Maker

Date (dd/mm/yyyy)

Signature of Witness

Date (dd/mm/yyyy)