

Indigenous Health Patient Referral Form

2735 Pembina Highway • Winnipeg, Manitoba • R3T 2H5
 Telephone: 204-940-8880 or 1-877-940-8880 • Fax: 204-943-1728

PRIORITY: Urgent (contact immediately) Regular (contact within 24 hours)

DEMOGRAPHIC & ADMISSION INFORMATION

DATE:

Patient Name:

Sex: Gender (optional): Date of Birth:

Has consent been provided? Yes No (Indigenous Health may approach an *inpatient* to make an offer of support and to request consent)

Consent provided by: Patient OR Representative Name and Contact Information:

If Hospital Inpatient, specify hospital name, unit and program:

Complete this section only for all Outpatients who gave consent, and for all Inpatients who gave consent:

Patient Site: Community Outpatient/Client, specify program:

Long Term Care Resident, specify name:

Treaty/N Number: Home Community: PHIN:

English Language Level: No Barrier Full Barrier Partial Barrier

Language: Home Phone:

Work Phone: Mobile Phone:

Mailing Address: City: Province:

Postal Code Evacuee: No Yes MedEvac: No Yes

Hospital Admission Date: Admitting Diagnosis:

Hospital Discharge Date:

Is there a scheduled appointment requiring travel to Winnipeg? No Yes, provide details below (or attach):

REASON FOR REFERRAL (mark an X in all that apply)

- Assessment/Support (inpatient) Interpretation Discharge Planning Spiritual Cultural Care
 Advocacy AMC Navigator Hospital FNIHB TB Collaboration (only for use of integrated TB staff)

REFERRAL SOURCE (if not the Patient)

Name of Referral Source (if not patient): Relationship/Title: Phone (indicate h, w or m):

Organization: Contact this person first? No Yes

COMMENTS:

Signature Printed Name and Designation Date:

Legend:
 AMC = Assembly of Manitoba Chiefs PHIN = Personal Health Information Number TB = Tuberculosis
 FNIHB = First Nation Inuit Health Branch Phone (h, w or m) = home, work or mobile

If consent given, also attach relevant functional and/or cognitive assessments noting care needs, and/or workplace safety alerts

FORM COMPLETION GUIDELINE

1.0 INTENT/PURPOSE OF FORM

- 1.1. To facilitate written referrals to Indigenous Health (IH) – Patient Services, for Indigenous patients within WRHA facilities and programs; both inpatients and outpatients.

2.0 USED BY

- 2.1. This form may be completed by any WRHA health care team staff (acute and community-based), as well as by health professionals and community representatives outside of WRHA.

3.0 GUIDELINES FOR COMPETION OF FORM

- 3.1. **Priority:** “Urgent” should be contacted immediately; “Regular” should be contacted within 24 hours.
- 3.2. **Demographic:** place a client label or complete the demographic information requested in the top right hand corner. Providing Gender information is optional.
- 3.3. **Consent:**
 1. Place an X in the “Yes” box if Patient/Representative has provided consent to share personal health information with IH. Add contact information for Representative if applicable. Also, complete the fields inside the section titled, “Complete this section only for all Outpatients who gave consent, and for all inpatients who gave consent”.
 - **Treaty/N Number:** the registration number used to access health benefits under FNIHB Non-Insured Health Benefits program. A treaty number for First Nations people is 10 digits; an “N number” for Inuit is 8 digits and starts with an N.
 - **Community:** refers to community of origin, a.k.a. First Nation or Indigenous community.
 - **Language Level:** “No Barrier” means a person speaks fluent English; “Full Barrier” means a person speaks no English; and “Partial Barrier” means a person speaks functional, but limited English and would benefit from interpretation.
 - **Evacuee:** refers to a person who has been evacuated from their home due to emergency measures.
 2. Reason for Referral:
 - **Assessment/Support** - is when hospital unit staff are requesting an IH team member approach a patient to explain IH services, to offer support, and request consent. If the patient declines, the file is closed. If the patient consents, an assessment is done to screen for the need to involve other IH services. Assessments are typically done by an Interpreter Resource Worker.
 - **Interpretation** – of Cree, Ojibway, or Oji-Cree languages provided by an Interpreter Resource Worker. Inuit language interpretation requests are forwarded to the Inuit Centre.
 - **Discharge Planning** – for individuals coming from/returning to Indigenous communities, or where jurisdictional issues require navigation support provided by a Regional Discharge Planning Coordinator.
 - **Spiritual Cultural Care** – consisting of prayer, teachings and access to ceremony in a WRHA facility provided by a Spiritual Cultural Care Provider.
 - **Advocacy** – concerns/complaints about care provided by WRHA that are being escalated to the Regional Patient Advocate.
 - **AMC/PAU** – navigation/outreach in the community that is provided for WRHA clients by Assembly of Manitoba Chiefs – Patient Advocate Unit.
 - **Hospital FNIHB** – facilitation of the WRHA Hospital Communication Form that is being sent to the First Nation Inuit Health Branch – Transportation Referral Unit, specifically for the purposes of requesting logistical supports.
 - **TB Collaboration** – for referrals from Integrated TB Service; these go to the Regional Patient Advocate for review and disposition.
 3. **Comments:** provide additional details about scheduled appointments, if applicable, and about the reason for requesting service from IH

4.0 FILING/ROUTING INSTRUCTIONS

- 4.1. Forms may be completed electronically in the Electronic Medical Record (EMR) where possible. A secondary option could be to complete using a paper copy and scanning into the EMR.
- 4.2. Sites that do not use the EMR will complete a paper copy and file it in the paper chart, per program guidelines.

5.0 PRINTING INSTRUCTIONS

- 5.1. Community Standard – White bond paper, black ink, two hole top punch, and head to head (tumble print) for two sided forms.

6.0 AUTHOR

- 6.1. WRHA Indigenous Health – Patient Services