HealthLinks / Maillonssanté
Champlain Region
Let's Make Health Change Happen / Favorisons la santé

Identification Form

Fax to: 613-745-0956
Toll-free Fax: 1-844-726-3010

Date of Identification: [Date] DD / MM / YYYY Identification Source: Choose an item.
Contact Name: Title & Organization (if applicable):
Contact phone #: Contact fax #: Contact Email:
Health Link Area (if known): Choose an item. Care Coordinator (if already assigned):

Patient Demographics

Health Card #: Check if no Health Card #: Unknown ☐ No Health Card # ☐ Other ☐ _____
Surname: Given name:
Address: City: Province: Postal Code:
Daytime Phone #: Alternate Phone #:
Preferred Official Language: English ☐ French ☐
Preferred Language of Service: English ☐ French ☐
Other ☐ _____
Interpreter required: Yes ☐ No ☐
Date of Birth: [Date] DD / MM / YYYY
Gender: Male ☐ Female ☐ Intersex ☐
Trans (Female to Male) ☐ Trans (Male to Female) ☐
Two-Spirit ☐ Other (please specify) ☐ _____
Do not know ☐ Prefer not to answer ☐
Primary Contact (if other than client): Relationship: Spouse ☐ POA ☐ Other ☐ _____
Phone #: Alternate #:
Aware of identification for Health Links: Patient ☐ Primary Contact ☐
Safety Precautions (e.g.: infectious disease, history of violence, pets etc.):

Primary Care

Primary Health Care Provider (e.g., MD or NP): Aware of Health Link Identification ☐
Contact Phone #: Contact Fax #:

Reason for Identification (please be specific/expectations)

☐ Additional documentation attached (e.g. Discharge Summary)

Health Link Criteria **☐ 4+ Chronic Conditions**

☐ **Mental Health** ☐ **Palliative** ☐ **Frailty** ☐ **Dementia**
☐ **Chronic Pain** ☐ **Hypertension** ☐ **Diabetes** ☐ **Cancer**
☐ **Arthritis and related disorders** ☐ **Developmental Disability**
☐ **Neurological disorder** ☐ **Liver disease**
☐ **Kidney disease** ☐ **Lung disease** ☐ **Heart disease**
☐ **HIV/AIDS** ☐ **Amputations** ☐ **Substance abuse**
Other (list all that apply): _____
_____
_____

☐ Any of the following:

☐ Lives alone/Isolated ☐ No social supports
☐ Risks for general safety ☐ Recent immigration
☐ Abuse (past, present) ☐ Food insecurity
☐ Low individual income ☐ Unemployment
☐ No knowledge of official languages
☐ Housing concerns
☐ Other (list all that apply): _____
_____
_____

Important Considerations: ☐ Frequent Hospitalizations ☐ Frequent ED visits
☐ Frequent missed appointments ☐ Frequent use of crisis services ☐ Frequent Primary Care appointments
☐ At risk of imminent decline ☐ Additional Areas of Concern: _____

List Other Known Service Providers: