NIHS

Department of Health

NIHS Appt Form

Health Canada Protected When Completed
Client Referral Form

Section A: Client Information

Surname _____

Given Name _____

10 Digit Band # _____

D.O.B. _____

Phone # _____

Address _____

_____

HC# _____

Addressograph

Section B: Referral Information Completed By:

Referring Health Care Provider _____

Medical Condition _____ ___ Diabetic

Is an Escort Recommended? _____ Yes _____ No If yes reason _____

_____

Escort Name _____

Reason for Referral

___ Consult/Councilling ___ Treatment
___ Confinement ___ Admission
___ Follow-up ___ Surgery

Diagnostic Test ___ Scan ___ X-ray
___ MRI ___ Scope
___ Mammogram ___ Biopsy
___ Ultrasound ___ Labwork
___ Other (type) _____

Specialist/Facility

Name _____ Specialty _____

Location of Appointment _____

_____

Phone _____ Fax _____

Referring Health Care Provider Signature _____

Section C: Appointment Information

Appointment Date _____ Time _____ Confirmation Required ___ Yes ___ No
Date _____

Special Instructions/Needs

_____

_____

_____

NIHS Approval
Signature _____ Prior Approval # _____ Date _____

Please fax the completed form to 1-807-737-3879