SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE
iCare

DEMOGRAPHIC LABEL

Crisis Community Navigation Team Referral

(Case-by-case need will be assessed upon referral)

PHONE: (705) 989-2558 FAX: (705) 759-3873

Last Name: _____ First Name: _____ Preferred Name: _____

D.O.B.: _____ Address: (if different from label) _____

City: _____ Province: _____ Postal Code: _____

Telephone #: (10 digits) _____

INCLUSION CRITERIA

- Designated Psychiatric ALC
- At risk of Psychiatric ALC designation
- Frequent Emergency Department visits or re-admissions related to Mental Health and Addictions
- Resides in Sault Ste. Marie & Surrounding First Nations Communities
- 18+ years

Date: _____ Referral Source: _____

Patient is aware of referral and provided consent: ☐ Yes ☐ No

Gender: ☐ Male ☐ Female ☐ Other: _____

Language of Need: ☐ English ☐ French Other: _____

Referral Completed by: _____ Phone: _____ EXT: _____
print name

Reason for Referral:

_____

_____

_____

_____

Additional Information:

_____

_____

_____

Please Fax completed referrals to number provided and contact via phone to confirm receipt.