SIOUX LOOKOUT
Meno Ya Win
HEALTH CENTRE

Meno Yan Win Internal Medicine Assessment Clinic (IMAC), Fax: 519-445-1917

Patient Demographics Phone Number

Last Name First Name Please enter a valid contact number Address Date of Birth

Street City Province Postal Code Day/Month/Year Health Card Number Email Address Consent to use of Email

10-digit number Version Code

Next of Kin (Emergency Contact) Phone number

Date of Referral Referring Physician/HCP Phone Number Fax Number and Referral Location

Please indicate urgency of referral.

☐ Urgent (Within 2-5 days)	☐ Semi-Urgent (within 1-2 weeks	☐ Routine (within 3-4 weeks)

Please note that patient will be triaged and the urgency status may change.

Reason for Referral

Relevant PMHx, Meds, Medical Investigations-please indicate if information is available on Meditech

Please indicate if patient requires any kind of assistance (check all that apply

☐ **Cognitive Impairment**	☐ **Mental Health History**	☐ **Mobility Issues**	☐ **Hearing Impairment**
☐ **Vision Impairment**	☐ **Translator Required (please indicate language):**		
☐ **Other**			

Referring Physician's/Healthcare Provider(HCP) Signature Billing Number (If applicable)