Muskoka Health Link facilitates bringing care providers together to coordinate and improve care delivery for individuals living with complex and chronic health needs.

Client Eligibility & Referral

Step 1: Checklist and Referral Information

INSTRUCTIONS: Please securely fax the completed referral & consent to ***705-645-9358.***
If you have any questions call us at: 705-645-2412 ext. 1210

A. CLIENT INFORMATION

** This information is required to register a client with Health Link. Please complete ALL fields in this box.**

*Date this form was completed:__________________
*Client Name: ________________________________ * Date of Birth (mm/dd/yyyy):______________
*Client Phone: (______) ______________________ *Town/Community: ______________________
*Client Address: ______________________________ *Postal Code: _________________
*Heath Card Number: __________________________ *Gender: ☐Female ☐Male ☐Other________
(Please include version code letters, if possible)

*Check any that apply: ☐Indigenous (First Nations, Metis, Inuit) ☐Veteran ☐French-speaking
(There may be additional services and resources available if any of these are relevant.)

B. HEALTH LINK CARE TEAM

*Name of person who completed this form: __________________________ Phone: (___) ___________

Organization: ______________________ Email: _________________________________

Has a Coordinated Care Plan (CCP) been developed? ☐Yes ☐No
(CCP includes name of System/Care Navigator, names of Care Team Members, summary of client needs and goals, linkage to advanced care planning if appropriate, and has been developed with client and/or caregiver, System/Care Navigator, and Care Team.)

If Yes, provide the date when the CCP was developed *(mm/dd/yy):*	**If Yes,** please provide the name of the organization/agency where the CCP is stored:

C. HEALTH LINK CLIENT ELIGIBILITY IDENTIFICATION

Use the criteria below to identify if the individual living with complex conditions is a ***high user*** *of the health system and/or* ***at risk of becoming a high user****. (Eligible clients must meet* ***at least one****. Check all that apply.)*

☐ Individual hospitalized in the last 3 months	☐ 1 or more visits to the emergency department in the last month	☐ Greater than 3 contacts with Primary Care Provider in the last month

☐ Greater than 3 organizations providing care to this individual

Please list organizations/individuals that are involved, if known.

Organization	Contact Name	Contact Email	Contact Phone

*Client Name: ______________________________ *Person who completed this form:___________________________

D. ADDITIONAL HEALTH LINK CRITERIA

*Additionally, identify if the client meets **4 or more** of the identified criteria below. (Eligible clients must meet **at least four**. Check all that apply. If less than four, please provide further reasoning for referral below.)*

☐ Lives Alone	☐ Caregiver Burnout	☐ Cognitive Impairment / Dementia
☐ Poor Nutrition ☐ Failure to Cope at Home ☐ Low Income/ Ontario Works / ODSP	☐ Chronic Disease(s) (e.g. diabetes, CHF, COPD, cancer, other): ***Please list.***	☐ Mental Health Issues (e.g. depression, bipolar, PTSD, schizophrenia, other): ***Please list.***
☐ Frail ☐ Multiple Medications (5+) ☐ Risk of Falling ☐ End of Life / Palliative	☐ Addiction Issue(s) (e.g. alcohol, smoking, drugs, gambling, other): ***Please list.***	☐ Identified Disability (e.g. physical, visual, hearing, other): ***Please list.*** ☐ Other: ***Please list***.

What prompted this Health Link referral?
(Please provide further information on the client's situation, needs, barriers, goals, care team members, etc.)
Notes:

E. ACCESS TO PRIMARY CARE

Does Client have a Primary Care Provider (PCP) - Doctor or Nurse Practitioner? ☐Yes ☐No

If Yes, provide name of PCP: ____________________________ PCP Phone: (_____) _____________________

F. HEALTH LINK CLIENT CONSENT

Client and/or Health Substitute Decision Maker / Power of Attorney accepts Health Link service and has completed the attached consent form:

☐**Yes** ☐**No** **If No**, please identify reason: ____

Please fax the consent form with this referral in order to grant permission for Health Link to follow up.

Please ***fax*** completed Health Link ***CLIENT REFERRAL FORM*** and signed Health Link ***CONSENT FORM*** to:

705-645-9358

To be completed by Health Link office staff:
Confirmation sent to referral source: ☐ Yes ☐ No Method:__________ Date: ____________ Confirmed by:_________