HealthLink
Muskoka HealthLink
Let's Make Healthy Change Happen

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

** Crucial information needed for the Health Link team to connect for follow up. Please complete.*

A. CLIENT INFORMATION

Date this form was completed:_______________

***Client Name**: ______________________________ Date of Birth (mm/dd/yyyy):_________________
(Health Link is NOT age specific)

***Client Phone**: (_____) ____________________________

Client Address: ____________________________________ Town/Community: __________________

***Heath Card Number**: __________________________ Gender: ☐Female ☐Male ☐ ____________
(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	☐ Chronic Disease(s) (e.g. diabetes, CHF, COPD, cancer, other): ***Please list.***	☐ Mental Health Issues (e.g. depression, bipolar, PTSD, schizophrenia, other): ***Please list.***
☐ Failure to Cope at Home		
☐ Low Income/ Ontario Works / ODSP		
☐ Frail	☐ Addiction Issue(s) (e.g. alcohol, smoking, drugs, gambling, other): ***Please list.***	☐ Identified Disability (e.g. physical, visual, hearing, other): ***Please list.***
☐ Multiple Medications (5+)		
☐ Risk of Falling		
☐ End of Life / Palliative		☐ 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:__________