Name: Preferred Name: DOB: HCN: Gender Identity: ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer not to say Sex assigned at birth: ☐ Male ☐ Female Address: City: Postal Code: Preferred Phone Number: Can message be left: ☐ Yes ☐ No Email:	Referral Date: <hr> Referrer Name: Referrer Phone: <hr> Referrer Location (e.g., ER, Public Health, Specialist):

Preferred Clinic location:

☐Listowel ☐ Wingham ☐ Stratford ☐ Exeter ☐ Zurich ☐ Goderich

Please verify that patient meets eligibility criteria for Unattached Patient Clinic (must answer YES to both):

Is patient <u>without a family physician</u>? ☐YES ☐NO

    NOTE: Patients with a family physician and/or from outside of the Huron Perth area are NOT eligible for this program

Does patient <u>reside in the Huron and Perth Area</u> (program catchment area)? ☐YES ☐NO

Reason for Referral/ Primary Care Needs:

Please attach medication list, recent investigations, allergies, and past medical history if available.

Referrer Signature:

Clinic Admin Only
Appointment Date/Time: **Provider:**

Fax to:

Stratford: 226-779-4225 - Listowel/Wingham: 519-357-3928 - Goderich/Exeter/Zurich:519-236-7162