NL Health Services

Indigenous Patient Navigator Referral
Western Zone

Name: _____ Date of Birth: DD/MONTH/YYYY

Home Address: _____

Telephone: _____ Email Address: _____

MCP/HCN Number: _____

Reason for referral (check all that apply):

☐ Smudge ☐ Hospital navigation ☐ Connect to cultural supports

☐ Indigenous services/benefit navigation ☐ Accompany individual to appointments

☐ Other: _____

Provide any pertinent information:

_____

_____

_____

_____

_____

_____

_____

Patient Location (specify facility and floor/unit):

☐ Hospital: _____

☐ Long term care facility: _____

☐ Other: _____

☐ I confirm the individual is aware of and has agreed to this referral.

Referred by: _____

Position/title: _____

Location: _____

Telephone: _____

Referring signature: _____ Date: DD/MONTH/YYYY

Email (internal only) or fax (external) fully completed referral to:
Indigenous Patient Navigator
Email: ipn.western@nlhealthservices.ca
fax: 709-634-7739
If you have any questions or need assistance with this form, call 709-640-9007