

New Canadian Clinics Referral Form

Patient Reviewed ✓

The New Canadian Clinics give **short-term, temporary** healthcare to refugees who do not have a primary care provider.

Instructions:

- See inclusion and exclusion criteria before filling out this form.
- *We reserve the right to accept and decline applications based on the information provided.*
- Complete page 1 and 2 of this form
- Fax completed referral form and all required documents to:

Patients who live in Surrey and North Delta:

Surrey New Canadian Clinic

Fax: 604-953-9711

Patients who live in Burnaby

Burnaby New Canadian and Global Family Care Clinic

Fax: 604-515-7750

Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none"> • Date of arrival within 12 months and one of the following: <ul style="list-style-type: none"> ○ Government-assisted refugees ○ Privately-sponsored refugees ○ Refugee claimants <p>Priority Given to People with 2 or more conditions below:</p> <ul style="list-style-type: none"> • Multiple barriers (low health literacy, trauma, mental health) • Children with disability • Complex health or social issues • No health insurance 	<ul style="list-style-type: none"> • Visitor, student, or work visa • Other immigration without refugee status (spousal sponsorship) • Already attached to a doctor or nurse practitioner

Include at least one of following documents with referral form for each patient:

Interim Federal Health Documents

Interim Federal Health Certificate of Eligibility

Refugee Protection Claimant Document or Acknowledgement of Claim and Notice for Return for Interview

Does patient have Interim Federal Health Program coverage? Yes No

<p>For Office Use Only: Referral <input type="checkbox"/> Accepted <input type="checkbox"/> Declined</p> <p>Comments:</p>
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New Canadian Clinics Referral Form Cont'd

Page: 2 of 2

Referral Information: *Complete one referral form for each patient*

Reason for referral (medical concerns): _____

Referring organization's name _____ Self-referred: check if yes

Date referred: _____ Referred by (name): _____

Email: _____ Phone: _____ Fax: _____

Number of family members in patient's family unit: _____ (*documentation for each family member required*)

Name of primary contact in patient's family: _____

Primary contact Phone _____ Primary Contact Email _____

Patient Information: *Please print legal name as shown on Canadian government issued ID*

First Name: _____ Last Name: _____

Date of Birth (dd/mm/yyyy): _____ BC Service Card number: _____

Current Gender: Male Female Other: _____

Home Address:

(Street) (City/Province) (Postal Code)

Phone: _____ Email: _____

Refugee Status:

Government Assisted

Interpreter Required: Yes No

Privately Sponsored (*who sponsored?*):

Languages Spoken: _____

Birth Country: _____

Claimant status (*pending/accepted/declined*):

Date arrived in Canada (dd/mm/yyyy): _____

Other: _____

Have they seen a doctor or nurse practitioner since their arrival in Canada? No Yes.

Name of doctor or nurse practitioner: _____

Where did they see the doctor or nurse practitioner?

Emergency Urgent Primary Care Centre Walk-in Clinic Community Family Practice Clinic

Other _____