elevate NWO

HIV | AIDS | HCV | HARM REDUCTION

For Elevate NWO use only	Date received:

PROVIDER REFERRAL FORM

102-106 Cumberland St Thunder Bay ON P7A 4M2 | Phone: 807-345-1516 | Fax: 807-333-0090

CLIENT INFORMATION

Attach label or clearly hand-write, make sure contact information/location is clear. Email address, phone number, alternative contacts are helpful.

Name:
Date of Birth:
Address:

Phone:
Email:

Can a confidential message be left?
☐ Yes ☐ No

REFERRAL SOURCE INFORMATION

Name:
Address/Clinic:
Phone:
Fax:

Signature:

Does the client consent to this referral?
☐ Yes ☐ No

REASON FOR REFERRAL

☐ HCV ☐ HIV ☐ PrEP ☐ PEP follow up
☐ Harm Reduction ☐ Other:

Please attach any supporting documentation OR complete the following (if known):

HIV Serology
Date of test:
Result:

Anti-HCV Antibody
Date of test:
Result:

HCV RNA
Date of test:
Result:

Clinician Name:

Signature:

Elevate NWO provides services to people who are part of the priority populations listed below. Please check all that apply.

PRIORITY POPULATION (HIV)
- ☐ Gay, Bisexual and all other men who have sex with men
- ☐ African, Caribbean and Black Communities
- ☐ People who inject drugs
- ☐ Indigenous Peoples
- ☐ Women who in engage in HIV risk activities with members of the above populations

PRIORITY POPULATION (HCV)
- ☐ People who inject drugs
- ☐ People involved with the correctional system
- ☐ People who are experiencing homelessness or who are underhoused
- ☐ Indigenous Peoples
- ☐ Youth

PAST MEDICAL HISTORY	MEDICATIONS
ADDITIONAL COMMENTS	PRIMARY CARE PROVIDER ☐ Same as above Name: Address/Clinic: Phone: Fax:

Form version: Feb. 2024

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SIGNATURE DATE

PLEASE BRING THIS FORM AND ANY SUPPORTING DOCUMENTATION
TO OUR OFFICE ***or*** FAX TO **(807) 333-0090**