NORTHERN HEALTH REGION

Indigenous Elder / Knowledge Keeper Referral

Client _____

_____

DOB (dd/mmm/yyyy) _____

HRN / MHSC _____

PHIN #: _____

Place Client Label Here

Location ☐ Flin Flon ☐ The Pas ☐ Thompson

Date of Referral _____ (DD/MMM/YYYY) **Facility** _____

Floor and Room Number _____

Referral made by _____ **Department** _____

Client is Aware of Referral ☐ Yes

Reason for Referral

☐ Ceremony (Smudge or Other) ☐ Traditional Teachings ☐ Traditional Medicine

☐ Emotional or Spiritual Support ☐ Birth or OBS Support ☐ Palliative Support

☐ Language or Interpretive Services

Additional Comments

_____

_____

_____

_____

_____

Referral Source

_____ _____

Name (Please Print) Signature