Primary Care Access Attachment Team (PCAAT) Family Referral Form

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PCAAT Referral Criteria (must meet all three):

- Client is not currently rostered with a family physician or primary care nurse practitioner.
- Client is 16 years of age or older OR is part of a family unit in need of primary care attachment.
- Client belongs to at least one equity-seeking group facing barriers to accessing primary care independently (i.e. unhoused or precariously housed, new to Canada, living with a disability and/or mental health challenges, member of the BIPOC and/or 2SLGBTQIA+ communities, etc.).

Note: PCAAT is unable to provide mental health support for individuals under the age of 16.

Worker-Identified Support Needs:

☐ Primary Care ☐ Addiction Support
☐ Mental Health Support ☐ Self-Care

Additional Information:

<u>Client Information</u>

Legal Name:	**Preferred Name:**
Gender:	**Pronouns:**
DOB: (y/m/d):	**Health Card No:**
Address:	**City:**
Phone Number:	**Can a voicemail be left?** ☐ YES ☐ NO

<u>Spouse Information</u>

Legal Name:	**Preferred Name:**
Gender:	**Pronouns:**
DOB: (y/m/d):	**Health Card No:**
Address:	**City:**
Phone Number:	**Can a voicemail be left?** ☐ YES ☐ NO

Good Shepherd Faith in people. Shelter Health Network Canadian Mental Health Association Hamilton Mental health for all REFUGE NEWCOMER HEALTH Where humanity meets healthcare. THE HAMILTON SOCIAL MEDICINE RESPONSE TEAM

Dependent Information

Legal Name: **Preferred Name:**

Gender: **Pronouns:**

DOB: (y/m/d): **Health Card No:**

Legal Name: **Preferred Name:**

Gender: **Pronouns:**

DOB: (y/m/d): **Health Card No:**

Legal Name: **Preferred Name:**

Gender: **Pronouns:**

DOB: (y/m/d): **Health Card No:**

Do any family members require an interpreter? ☐ YES ☐ NO ☐ UNKNOWN
Details:

Do any family members require any accessibility accommodations? ☐ YES ☐ NO ☐ UNKNOWN
Details:

Do any family members have affiliation to the Shelter Health Network? ☐ YES ☐ NO ☐ UNKNOWN
Details:

Do any family members have a family physician? ☐ YES ☐ NO ☐ UNKNOWN
Details:

What barriers, if any, has the family experienced accessing a family physician?

Is there additional information the family would like PCAAT to be aware of?

Referring Agency

Agency Name: **Agency Phone Number:**

Worker Name:

Worker's Signature: **Date:**

● Please fax all referrals and inquiries to (905) 667-7661 ●