Grand River Community Health Centre

something to smile about

Something To Smile About Referral Form

CLIENT IDENTIFICATION

Name_____ Date of Birth (DD MM YR) ____/_____/_____

Address _____ City _____ Postal Code _____

Telephone _____ Alternate phone_____ No phone available ☐

Email_____ Preferred method of contact _____

Do you receive primary care and/or counselling services from a provider at GRCHC? Yes ___ No ___

Have you attended a group program at GRCHC? Yes ___ No ___

REASON(S) FOR REFERRAL (please check all that apply):

☐ Pain/discomfort ☐ Trouble eating ☐ Trouble breathing ☐ Self-esteem/confidence ☐ In need of dentures	☐ Affecting relationships ☐ Affecting employment ☐ Stress/mental health ☐ No dental insurance ☐ Other _____

Additional information:

Referral Source (please circle):

Self	Primary Health Care Provider	Other _____

Signature _____ Date _____