**RICHER Social Pediatrics Program**
***NP Family Primary Health Care &***
***Pediatric Specialist Outreach Services***
**Ph: 604-875-2246 Fax: 604-875-3958**

# RICHER Referral (Primary Care/ Specialist services)

**DATE:** ____________________ **PATIENT NAME:** ____________________
month day year

**CARE CARD #:** ____________________ **DATE OF BIRTH:** ____________________
MONTH DAY YEAR

**PARENT/CAREGIVER(S):** ____________________ **RELATIONSHIP:** ____________________

**ADDRESS:** ____________________ ☐ **HOME PHONE:** ____________________

____________________ ☐ **WORK/CELL:** ____________________

☐ **EMAIL CONTACT IF AVAILABLE:** ____________________
*PLEASE TICK OFF BEST WAY TO REACH FAMILY

**LANGUAGE(S) SPOKEN AT HOME:** ____________________ **INTERPRETER REQUIRED:** ❑ **YES** ❑ **NO**

**REASON FOR REFERRAL:** ____________________

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____________________

***PLEASE INCLUDE ANY SUPPORTING DOCUMENTATION RELEVANT FOR THIS REFERRAL.**

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**REFERRAL SOURCE (IF RELEVANT):** ____________________ **TITLE:** ____________________
***PLEASE NOTE, YOU MAY BE CONTACTED TO SUPPORT AND FACILITATE THIS REFERRAL, AS OUR PROGRAM RELIES ON "BROKERED TRUST" FOR SUCCESSFUL CONNECTION. THIS MAY TAKE THE FORM OF ACCOMPANIMENT OR JOINT VISITS, ESPECIALLY AT THE BEGINNING, WHERE SUCH STRATEGIES MAY BE NECESSARY AND POSSIBLE.**

**EMAIL CONTACT:** ____________________ **PHONE:** ____________________

**SCHOOL/PRESCHOOL/DAYCARE:** ____________________ **PHONE:** ____________________

**EMAIL CONTACT:** ____________________

**PRIMARY HEALTH CARE PROVIDER (GP OR NP):** ____________________ **PHONE:** ____________________

**CLINIC NAME AND CONTACT:** ____________________

**OTHER COMMUNITY SUPPORTS INVOLVED AND CONTACTS (I.E. SOCIAL WORKER, COMMUNITY SERVICES, FAMILY, FRIENDS, ETC):**

____________________

____________________

**PLEASE REVIEW ATTACHED CONSENT WITH FAMILY PRIOR TO FORWARDING THIS REFERRAL.**

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**Office Use Only:**
**Assigned to: NP ❑** **Pediatrician ❑** **Developmental Pediatrician ❑** **Psychiatrist ❑**
INTERNAL TRIAGE NOTES:

 Updated Sep '22

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**RICHER Social Pediatrics program is a community-based team of Nurse Practitioners and Pediatric specialists. We aim to meet the unique needs of children, youth and their families who have historically faced systemic barriers to accessing care. We work within the communities of Strathcona, DTES and Grandview Woodlands.**

## Consent for Release of Information

Patient name: ______________________________________________

Address and Contact:

______________________________________________

______________________________________________

DOB: ______________________ PHN: ______________________

I give the RICHER Program permission to communicate with the referral source about

______________________ for the purpose of facilitating this referral.

______________________________ ______________________
Signature of Patient or Guardian Date

______________________________ ______________________
Witness name Witness signature Date

Authorization by verbal consent:

______________________________ ______________________
Witness name Witness signature Date