

Confidential Fax Referral Form

Southwestern Public Health iHeal Program

Referral Date: _____

Referred By:

Name: _____
Agency: _____

Phone Number: _____

Client Information:

Name: _____
DOB: _____
Address: _____

Patient is aware of this referral (Yes) or (No)

Patients preferred method of contact:

(Email) (Phone) (Text) (WhatsApp)

Phone#: _____ **Email:** _____

Reason for Referral:

All personal health information and personal information collected on this form is done under the [Health Protection and Promotion Act R.S.O. 1990, c.H.7](#) and in accordance with the [Personal Health Information Protection Act, 2004, S.O. 2004, c.3. S.](#) and [Municipal Freedom of Information and Protection of Privacy Act R.S.O. 1990, c. M.56](#). This information will be used by Southwestern Public Health for the purpose of providing public health programming, quality improvement, and statistical/research purposes as required or permitted by law. Questions or concerns regarding this collection can be directed to the Manager, Records & Privacy Compliance (1230 Talbot St, St. Thomas Ontario N5P 1G9, or privacy@swpublichealth.ca).