NL Health Services

INDIGENOUS PATIENT NAVIGATOR REFERRAL
Western Zone

Name: _____ **Date of Birth**: _____

MCP/HCN #: _____ **Telephone #**: _____

Home Address: _____

Email Address: _____

Reason for referral (Please check all that apply):

- ☐ Smudge
- ☐ Connect to Cultural Supports
- ☐ Accompany Individual to Appointment(s)
- ☐ Other _____
- ☐ Hospital Navigation
- ☐ Indigenous Services/Benefit Navigation

Please provide any pertinent information:

_____

_____

Patient Location (specify facility and floor/unit):

- □ Hospital: _____
- □ Long Term Care Facility: _____
- □ Other: _____

☐ **I confirm the individual is aware of and has agreed to this referral**.

Referred By: _____

Position Title: _____

Location: _____

Telephone #: _____

Referring Signature: _____ **Date** _____

Please email (internal only) or fax (external) fully completed referral form to:

Indigenous Patient Navigator
Email: ipn.western@nlhealthservices.ca
Fax: 709-634-7739
If you have any questions or need assistance with this form, please call: 709-640-9007

12-3775
Revised: April 2025