



Primary Care Access Attachment Team (PCAAT) Referral Form

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 | ☐ Mental Health Support |
| ☐ Addiction Support | ☐ Peer Support |

Additional Information:

Client Information

Legal Name: _____ Preferred Name: _____

Gender: _____ Pronouns: _____

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

Address: _____ City: _____

Phone Number: _____ Can a voicemail be left? ☐ YES ☐ NO



Does the client require an interpreter? ☐YES ☐NO ☐UNKNOWN

Details: _____

Does the client require any accessibility accommodations? ☐YES ☐NO ☐ UNKNOWN

Details: _____

Does the client have affiliation to the Shelter Health Network? ☐YES ☐NO ☐UNKNOWN

Details: _____

Does the client have a family physician? ☐YES ☐NO ☐UNKNOWN

Details: _____

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

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

Referring Agency

Agency Name: _____ Agency Phone Number: _____

Worker Name: _____

Worker's Signature: _____ Date: _____

☐ **Client aware and consents to referral**

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