North Simcoe Family Health Team
619 Prospect Blvd., Suite 3
Midland ON, L4R 0G3
(P) 705-526-7804 (F) 705-526-1205

Referral For Assessment for MOH ADP Mobility Aid Funding

Referral Information:

Client Name: ______________________________ **Date of Referral:**___________________________
Date of Birth: ______________________________ **Referred By:** _______________________________
Health Card Number: ________________________ **Best Person to Contact:** _____________________
Home Phone: ______________________________ **Relation to Client:** _________________________
Address: __________________________________ **Contact Number:** ___________________________

1) This patient requires the use of a rollator for all basic essential mobility (all walking):
☐ Yes ☐ No

2) This patient already has a rollator:
☐ Yes ☐ No

If yes explain need for new device: ________________________

Relevant Information:

IMPORTANT

Please note:

- **Form must be completed by a healthcare care provider (Family doctor or NP)**
- **This program can only assess for walker funding (no wheelchairs, scooters etc.)**
- **Appointments to be scheduled when able, wait times can exceed 1 month**

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