**Band#**

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| **Print Client Surname Given Name(s)** | | | | | | **Health Care No.** | | | | | | | | | | | | | Date of Birth | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  |  |  |  |  | | |  |  |  |  | | |  | | | |  | | | | |  | | | |  | | | |  | | | |  | | |
| Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Directions to the Home | | | | | | | | | | | | | | | | | | Phone No. | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | |  | | | | - | |  | |  | | | |  | | | |  |
| Contact Name | | | | | | | | | | | | | | | | | | Phone No. | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | |  | | | | **-** | |  | |  | | | |  | | | |  |
| **Referral Information:****(e.g. physician, nursing, rehab. and social services, health reps. and other community sources)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diagnosis | |  | | | | | | | | | | **Family Informed:**  **Client Informed:** | | | | | | | | | | | | | **Yes  No**  **Yes  No** | | | | | | | | | | | | | | | | | |
| Prognosis | |  | | | | | | | | | | **Family Informed:**  **Client Informed:** | | | | | | | | | | | | | **Yes  No**  **Yes  No** | | | | | | | | | | | | | | | | | |
| Medical History | |  | | | | | | | | | **PPS Score:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Current Medication | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Psycho-Social  History | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other Services Client  Receiving | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tests / Treatments  Requested | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other Information | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reason for Referral | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical History | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Services Requested | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Print Name of Referral Source\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Please Fax referral to 226-9649**  **or call 226-2864, 226-9665** | | | Position or Relationship to Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature of Referral Source (if available) | | | | | | | | | | | | | | | | | Date | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | | | |  | | | |  | | | |  | | | |  | | | |
| Address | | | | | | | | | | | | | | | | Phone No. | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | |  | | | | | **-** | |  | |  | | | |  | | | |  | |
| **Is this person currently a Home Care Client?** Yes  No  Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Home care Assessment: Yes  No | | | | Home care Services: Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Comments: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Print Case Manager’s Name | | Case Manager Signature | | | | | | | | | | | | | | | Date | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | | | |  | | | |  | | | |  | | | |  | | | |
| Address | | | | | | | | | | | | | | | | Phone No. | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | |  | | | | | **-** | |  | |  | | | |  | | | |  | |

**Notes**

* A referral may come from any source, e.g. physician, community health nurses, social workers and other healthcare staff, the clients themselves, family members or other community sources.
* To facilitate the referral process copies should be provided to likely sources such as Health and Social Service Centres, physicians’ offices, hospital nursing stations and rehabilitation departments.
* A Community Care Program Staff member also uses this form as the preliminary intake information form.