**Band#**

|  |  |  |
| --- | --- | --- |
| **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.