**Client Referral Form**

**Fax printed forms to:** **905-687-9952**

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| **Client/Patient Info** | | | | |
| Name: | Click to enter |  | Date of Birth: | dd/MM/yyyy |
| Address: | Click to enter |  | Family Doctor: | Click to enter |
| City: | Click to enter |  | Diagnosis: | Click to enter |
| Postal Code: | Click to enter |  | Diagnosis Date: | dd/MM/yyyy |
| Phone #: | Format 905-123-4567 |  | Living Situation: | Click down arrow. |
| Gender: | Click down arrow. |  | First Language: | Click down arrow. |

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| **Contact Person Info** | | | | | |
| Name: | Click to enter |  | Home Phone: | Format 905-123-4567 | |
| Address: | Click to enter |  | Alt Phone: | Format 905-123-4567 | |
| City: | Click to enter |  |  |  | |
| Postal Code: | Click to enter |  | Relationship to patient: | | Click to enter |
| E-mail: | Click to enter |  | Is this person the POA? | | Yes  No |

|  |  |  |  |
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| **Follow Up** | | | |
| Preferred Contact Person: | Client/Patient | | Contact Person |
| Preferred Contact Method: | Home Phone | | Alt Phone |
| Safe to leave message? | Yes  No | |  |
| Is client/patient aware of this referral? | | Yes  No | |

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| **Referred By** | | | | |
| Name: | Click to enter |  | Agency/Org: | Click to enter |
| Bus. Phone: | Click to enter |  | Discipline/Role: | Click to enter |

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| **Referral Specifics** | | | | |
| Provide Support and Education for:  Client  Caregiver  Other: | | | | Click to enter |
| interRAI CHA/HC completed?  Yes  No | | Date: | dd/MM/yyyy | |
| Risk to staff?  Yes  No | Specify: | Click to specify | | |
|  | | | | |
|  | | (eg. Aggression, infectious diseases, infestation, pets, physical environment, smoker, squalor, weapons, recent hospitalization) | | |
| **Reason for Referral (attach diagnostic testing as applicable):** | | | | |
| Click to enter reason(s) | | | | |