**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  |
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|  | (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) |