



Referral Form

Client Information

Date: _____

Name:	D.O.B:	
Address:	Client Contact #:	
	Health Card #:	
Client aware of referral: YES NO	Language Spoken:	
Attached Client Consent Form: YES NO	Need for Cultural Interpretation: YES NO	

Referral Source Information

Name:
Organization:
Phone # / fax #:

Does the client have a Health Practitioner? YES NO
 Practitioner Name: _____ Contact#: _____
 Is the Health Practitioner aware of this referral? YES NO

Reason for Referral:

Please check the following criteria that apply to the client.

- | | |
|---|------------------------------------|
| Does not have family doctor | ED visit in last 3 months |
| Lives alone/isolated | Taking more than 3 medications |
| No support network (friends, family) | Fallen in last 3 months |
| Difficulty keeping appointments/ no shows | New medical diagnosis < 3 month |
| Fear/ Concerns re: abuse | Chronic illness/ pain monitoring |
| At risk of eviction / Low Income | >10 lbs weight loss <2 month |
| Concerns of general safety | Recent change in mood/ behavior |
| Recent loss of spouse | Recent change in cognition/ memory |

If checked, please describe here:



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Does the client currently have any of the following services? If yes, please describe below.

CCAC Home Support G.P.C.S.O Day Hospital/ Program G.A.O.T Other

If checked, please describe here:

Infectious Diseases – Check all that apply.

HIV HEP C C DIFF MRSA TB VRE

Medical Conditions/Diagnosis:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

Current Medications / Prescribed by:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

PLEASE ATTACH A COPY OF ANY RECENT DISCHARGE REPORTS OR COMPLETED ASSESSMENTS

Safety Precautions – Does the client have a history of:

Aggressive Behavior Substance Abuse Bed Bugs Pets in Home Hoarding

Please contact Central Intake to further discuss any safety concerns you may have regarding the client

If checked, please describe here:

Expectations from PCO/Goals of Referral Source: