Central CCAC CASC
Community Care Access Centre | Centre d'accès aux soins communautaires du Centre

INTAKE AND LINKING REFERRAL FORM

Referral is: ☐ **Urgent** ☐ **Non-Urgent**

DEMOGRAPHIC INFORMATION

Health Card Number: **VC:** **Gender:** ☐ Male ☐ Female

Surname: **First Name:**

Address:
Street # Street Name Apt.#

City: **Postal Code:** **Entry Code:**

Home Phone: **Cell Phone:** **Date of Birth:** / /
(dd/mmm/yyyy)

CONTACT INFORMATION

Language Spoken/Preferred:

Alternate Contact Name:

Client Knowledge of Referral: ☐ Yes ☐ No

REFERRAL SOURCE

Name: **Relationship:**

Phone: **Agency:**

MEDICAL CONTACTS

Physician Name: **Address:**

Phone 1: **Ext.** **Phone 2:** **Ext.**

Cell Phone: **Fax:**

☐ **Attending** ☐ **Referring** ☐ **GP** ☐ **Other,** specify**:**

REASON FOR REFERRAL

Reason for the referral/presenting problem/comments:

☐ Nursing ☐ Physiotherapy ☐ Occupational Therapy ☐ Speech/Language Pathology
☐ Social Work ☐ Nutritional Services ☐ Long Term Care Placement ☐ Laboratory
☐ Personal Support (bathing, dressing only)
☐ Housekeeping, shopping, transportation – CCAC to mail or email community resources to client at:

_____

or client can contact Doorways to Care at 1-866-626-0222 for linking to community resources.

Has the client been in the ER/hospital within the last 14 days? ☐Yes ☐No ☐Unknown

Does the client haves a current cancer diagnosis? ☐Yes ☐No ☐Unknown

Has the client had any recent falls within the last 14 days? ☐Yes ☐No ☐Unknown

Has there been a recent change to the client's medical condition in the last 14 days? ☐Yes ☐No ☐Unknown

Can the client manage their medications? ☐Yes ☐No ☐Unknown

Is the client have any difficulties with bathing, dressing meals, housekeeping, driving to appointments, shopping, banking, etc.?

☐Yes, specify: _____ ☐No ☐Unknown

Is anyone assisting the client? ☐Yes ☐No ☐Unknown

Fax completed form to North York office 416-222-6517 or Newmarket office 905-952-2404