Ontario
Central Local Health Integration Network
Réseau local d'intégration des services de santé du Centre

Home and Community Care

Intake and Linking Referral Form

REFERRAL IS: ☐ **Urgent** ☐ **Non-Urgent**

PATIENT INFORMATION

_____
(Last Name, First Name)

Health Card Number and Version Code: _____ **DOB (dd-mmm-yyyy):** _____ **Gender:** ☐ Male ☐ Female

Home Address: _____
(Street #) *(Street Name)* *(Apartment/Room #)*

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

Home Phone: _____ **Cell Phone:** _____

CONTACT INFORMATION

Language Spoken/Preferred: _____

Alternate Contact: _____
(First Name and Last Name) *(Phone)*

Patient Knowledge of Referral: ☐ No ☐ Yes

REFERRAL SOURCE

Name: _____ **Relationship:** _____

Phone: **Agency:**

MEDICAL CONTACT

Physician Name: _____

☐ **Attending** ☐ **Referring** ☐ **GP** ☐ **Other - specify:** _____

Address: _____

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

Cell Phone: **Fax:**

REASON FOR REFERRAL

Reason for the referral/presenting problem/comments:

☐ Health Links ☐ Laboratory ☐ Long Term Care Placement ☐ Nursing
☐ Nutritional Services ☐ Occupational Therapy ☐ Personal Support (e.g. bathing, dressing) ☐ Physiotherapy
☐ Social Work ☐ Speech Lanuage Pathology
☐ Community Linking (e.g. housekeeping, shopping, transportation) - *Home and Community Care at Central Local Health Integration Network to mail or email community resources to patient at:*

Has the patient been in the ER/hospital within the last 14 days?	☐ Unknown	☐ No	☐ Yes
Does the patient have a current cancer diagnosis?	☐ Unknown	☐ No	☐ Yes
Has the patient had any recent falls within the last 14 days?	☐ Unknown	☐ No	☐ Yes
Has there been a recent change to the patient's medical condition in the last 14 days?	☐ Unknown	☐ No	☐ Yes
Can the patient manage their medications?	☐ Unknown	☐ No	☐ Yes
Does the patient have any difficulties with bathing, dressing, meals, housekeeping, driving to appointments, shopping, banking, etc.? • If "Yes" - specify:	☐ Unknown	☐ No	☐ Yes
Is anyone assisting the patient?	☐ Unknown	☐ No	☐ Yes

Fax completed form to: Newmarket Office (905) 952-2404 OR Sheppard Office: (416) 222-6517