HOME AND COMMUNITY CARE SUPPORT SERVICES
South East

Hospital Logo

Home and Community Care Support Services South East Referrals

Patient Identification Label

Estimated Date of Discharge (EDD): DD/MM/YYYY

Patient Details and Demographics

Health Card# | Version Code | Province Issuing Health Card

No Health Card #: ☐ **No Version Code:** ☐

Surname: | Given Name:

No Known Address: ☐

Home Address: | City: | Province:

Postal Code: **Telephone:** **Alternate Telephone:** **No Alternate Telephone** ☐

Address for Treatment (Complete if different from home address:

City: | Province:

Postal Code: **Telephone:** **Alternate Telephone:** **No Alternate Telephone** ☐

Date of Birth: **Gender:** ☐ **M** ☐ **F** ☐ **Other**

Patient Speaks/Understands English: ☐ **Yes** ☐ **No** **Interpreter Required:** ☐ **Yes** ☐ **No**

Primary Language: ☐ **English** ☐ **French** ☐ **Other**

Primary Alternate Contact Person:

(Please check all applicable boxes) **Relationship:** ☐ **POA** ☐ **SDM** ☐ **Spouse** ☐ **Other**

Telephone: **Alternate Telephone:** **No Alternate Telephone** ☐

Health Information

Community Primary Health Care Provider (e.g. MD or NP)

Surname: **Given Name(s):**

☐ None

Relavant Diagnosis for Referral: Please include any surgical procedure(s) and date(s):

Reason for Referral:

Allergies: ☐ **No Known Allergies** ☐ **Yes (if Yes, please list)**

Infection Control: ☐ **None** ☐ **MRSA** ☐ **VRE** ☐ **CDIFF** ☐ **ESBL** ☐ **TB** ☐ **Other (Specify)**

Medical Orders: ☐ **No** ☐ **Attached (Please include IV, CADD and/or therapy/equipment orders if indicated)**

Referring Facility / Unit: | Facility (department/unit) Telephone Extension Number:

Completed by: **Title:** Date: DD/MM/YYYY

Contact #:

Please fax referrals to Home and Community Care Support Services South East at 1-866-839-7299

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Ontario