

**HOME AND COMMUNITY CARE
SUPPORT SERVICES**

Champlain

Referral Form for Home and Community Care Support Services

For Community Referrals - Fax Form to 613.745.6984 or 1.855.450.8569

Estimated Date of Discharge (EDD):		(dd-mm-yyyy)	(when applicable)
Patient Details and Demographics			
Health Card #:	VC:	Province issuing Health Card:	
No Health Card #: <input type="checkbox"/>	No Version Code: <input type="checkbox"/>		
Surname:		Given Name(s):	
Home Address:		City:	Province:
No Known Address: <input type="checkbox"/>			
Postal Code:	Tel:	Alternate Tel:	
Address for Treatment: (Complete if different from Home Address):		City:	Province:
Postal Code:	Tel :	Alternate Tel :	
Date of Birth:	(dd-mm-yyyy)	Gender: M <input type="checkbox"/> F <input type="checkbox"/>	
Patient speaks/understands English:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary language:	<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other:		
Primary Alternate Contact Person:			
(Please Check All Applicable Boxes) Relationship: <input type="checkbox"/> POA <input type="checkbox"/> SDM <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____			
Tel:	Alternate Tel:	No Alternate Tel: <input type="checkbox"/>	
Secondary Alternate Contact Person:			
(Please Check All Applicable Boxes) Relationship: <input type="checkbox"/> POA <input type="checkbox"/> SDM <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____			
Tel:	Alternate Tel:	No Alternate Tel: <input type="checkbox"/>	

Health Information		
Community Health Care Provider (e.g. MD or NP)	Surname:	Given Name(s):
<input type="checkbox"/> None		
Relevant Diagnosis for Referral:		
Reason for Referral:		
Allergies: <input type="checkbox"/> NKA <input type="checkbox"/> Yes --- if Yes, List Allergies:		
Infection Control <input type="checkbox"/> None <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> CDIFF <input type="checkbox"/> ESBL <input type="checkbox"/> TB <input type="checkbox"/> Other (specify):		
Attachment(s): <input type="checkbox"/> None <input type="checkbox"/> Medical Orders <input type="checkbox"/> Primary Care <input type="checkbox"/> InterRAI-PS <input type="checkbox"/> Other(Specify): _____		

Referring Organization Information		
Referring Organization/Unit:	Organization Contact Number:	
Completed By:	Title:	Date:
Contact Tel:	Email address:	

Eligibility for Direct Services: Valid OHIP card; Assessment by a Health Care Professional.

If faxed, include Number of Pages (Including Cover): _____ Pages

Confidential when completed. If you have received this form in error, please call 1.800.538.0520.

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Referral – Primary Care Addendum

Last Name, First name:	<input type="text"/>	HCN:	<input type="text"/>	VC:	<input type="text"/>
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Detailed Health Information		
Primary Diagnosis	<input type="text"/>	
Secondary Diagnosis	<input type="text"/>	
PROGNOSIS <input type="checkbox"/> Improve <input type="checkbox"/> Remain Stable <input type="checkbox"/> Deteriorate <input type="checkbox"/> Maintenance	DIAGNOSIS DISCUSSED With Patient <input type="checkbox"/> Yes <input type="checkbox"/> No With Family <input type="checkbox"/> Yes <input type="checkbox"/> No	PROGNOSIS DISCUSSED With Patient <input type="checkbox"/> Yes <input type="checkbox"/> No With Family <input type="checkbox"/> Yes <input type="checkbox"/> No
Relevant Medical History	<input type="text"/>	
Surgical or other Procedures	<input type="text"/>	
Medication	<input type="text"/> *Mandatory* (Use separate sheet if required) List all medications for Medication Reconciliation Purposes.	
Diet	<input type="text"/>	
Allergies	<input type="text"/>	

Services Requested	Notes, Orders, and Contraindications
<input type="checkbox"/> Care Coordination <input type="checkbox"/> Nursing <input type="checkbox"/> Personal Support/Care <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Dietician <input type="checkbox"/> Social Work	<input type="text"/> Treatment will be taught and reduced, unless otherwise indicated.

Signature of Physician	
Signature:	Date:
Physician Name:	

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