

REFERRAL FORM FOR HOME AND COMMUNITY CARE SERVICES

PLEASE FAX COMPLETED REFERRAL FORM HOME AND COMMUNITY CARE SUPPORT SERVICES TORONTO CENTRAL 416-506-0374

PLEASE PRINT CLEARLY

CLIENT INFORMATION

LAST NAME: _____ FIRST NAME _____

HEALTH CARD # _____ VC _____ DATE OF BIRTH: DD _____ MM _____ YYYY _____

ADDRESS: _____ APT# _____ ENTRY CODE: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

PRIMARY TELEPHONE #: (_____) _____ ALTERNATE: (_____) _____

PREFERRED LANGUAGE: _____

PRIMARY CONTACT INFORMATION

LAST NAME: _____ FIRST NAME: _____

PRIMARY TELEPHONE #: (_____) _____ ALTERNATE: (_____) _____

PREFERRED LANGUAGE: _____

Reason for Home and Community Care Support Services Toronto Central Service Referral:

Has the client fallen within the last 30 days?: Yes No

Was the client in hospital within the last 30 days?: Yes No

Is the Client/POA/SDM aware of this referral: Yes No

REFERRAL SOURCE

NAME: _____ TELEPHONE: (_____) _____ FAX: (_____) _____

ADDRESS: _____ CITY: _____ PROVINCE: _____ POSTAL CODE: _____

PHYSICIAN / NURSE PRACTITIONER INFORMATION

REFERRING: PRIMARY CARE PRACTITIONER:

NAME: _____ TELEPHONE: (_____) _____ FAX: (_____) _____

ADDRESS: _____ CITY: _____ PROVINCE: _____ POSTAL CODE: _____

OHIP BILLING CODE: _____ CPSO# _____

SIGNATURE: _____

DATE: _____

**CONFIDENTIAL WHEN COMPLETED. IF YOU HAVE THIS FORM IN ERROR PLEASE DO NOT COPY OR DISPOSE OF.
CONTACT 416-506-9888 AND WE WILL MAKE ARRANGEMENTS TO COLLECT IT.**

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PLEASE PRINT CLEARLY

LAST NAME: _____ FIRST NAME: _____

HEALTH CARD # _____ VC _____

MEDICAL INFORMATION

PRIMARY DIAGNOSIS	
SECONDARY DIAGNOSIS	
ALLERGIES	
RELEVANT MEDICAL HISTORY	
MEDICATION	Name: _____ Dosage: _____ Frequency: _____ Route: _____ Duration: _____ Name: _____ Dosage: _____ Frequency: _____ Route: _____ Duration: _____ Name: _____ Dosage: _____ Frequency: _____ Route: _____ Duration: _____ Other: _____
MOBILITY	Ambulatory: <input type="checkbox"/> Yes <input type="checkbox"/> No Client uses: <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Scooter Other: _____
SERVICES REQUESTED	<h4 style="text-align: center;">PRESENTING ISSUES</h4> <p>*Important*</p> <ol style="list-style-type: none"> 1. Identify reason/need for each service selected. 2. Provide Treatment Orders and Start Date as applicable. 3. For Nursing Service - Clients will receive assessment and treatment at one of the Home and Community Care Nursing Clinics (in-home Nursing arranged by exception only).
<input type="checkbox"/> Nursing (including Nursing Clinics) <input type="checkbox"/> Community Linking (i.e. homemaking) <input type="checkbox"/> Dietician/Nutrition <input type="checkbox"/> LTCH Assessment <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Personal Care (bathing/dressing) <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Social Work <input type="checkbox"/> Speech Language Pathology <input type="checkbox"/> Case Management	
<input type="checkbox"/> Telehomecare	<input type="checkbox"/> CHF <input type="checkbox"/> COPD <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Emphysema
PHYSICIAN/NP SIGNATURE:	DATE:

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