

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
Home Address: _____ Female
(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:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Health Links | <input type="checkbox"/> Laboratory | <input type="checkbox"/> Long Term Care Placement | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Nutritional Services | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Personal Support (e.g. bathing, dressing) | <input type="checkbox"/> Physiotherapy |
| <input type="checkbox"/> Social Work | <input type="checkbox"/> Speech Language Pathology | | |
| <input type="checkbox"/> Community Linking (e.g. housekeeping, shopping, transportation) | | | |

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

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