HOME AND COMMUNITY CARE SUPPORT SERVICES
Toronto Central

250 Dundas Street West, Suite 305, Toronto, ON
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Fax: 416-506-0374
www.healthcareathome.ca/torontocentral

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

PATIENT 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 patient fallen within the last 30 days?: Yes ☐ No ☐
Was the patient in hospital within the last 30 days?: **Yes** ☐ **No** ☐
Is the Patient/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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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: ☐ Yes ☐ No** **Patient uses: ☐ Wheelchair ☐ Walker ☐ Cane ☐ Scooter** **Other:_____**	
SERVICES REQUESTED	***Mandatory Information*** 1. Identify reason/need for each service selected 2. Provide Treatment Orders and Start Date as applicable 3. For Nursing Service - Patients will receive assessment and treatment at one of the HCCSS Nursing Clinics (in-home nursing arranged by exception only) 4. Fax referral AND relevant documents together (i.e. script, Palliative Care Referral Form, etc)	
☐ **Nursing** (including Nursing Clinics) ☐ **Personal Care** (bathing/dressing) ☐ **Dietician/Nutrition** ☐ **Occupational Therapy** ☐ **Physiotherapy** ☐ **Speech Language Pathology** ☐ **Social Work** ☐ **LTCH Assessment** ☐ **Case Management** ☐ **Community Linking** (i.e. homemaking)		
☐ **Palliative Care**	**Prognosis: _____ Palliative Performance Scale (PPS): _____%**	
☐ **Rapid Response Nursing (RRN)**	☐ **CHF** ☐ **COPD**	
PHYSICIAN/NP NAME:		**OHIP BILLING CODE:_____ CPSO/CNO#:_____**
PHYSICIAN/NP SIGNATURE:		**DATE:**

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