



Referral Form

Client Information

Date: _____

Name:	D.O.B:
Address:	Client Contact #:
	Health Card #:
Client aware of referral: YES NO	Language Spoken:
Attached Client Consent Form: YES NO	Need for Cultural Interpretation: YES NO

Referral Source Information

Name:
Organization:
Phone # / fax #:

Does the client have a Health Practitioner? YES NO
Practitioner Name: _____ Contact#: _____
Is the Health Practitioner aware of this referral? YES NO

Reason for Referral:**Please check the following criteria that apply to the client.**

Does not have family doctor
Lives alone/isolated
No support network (friends, family)
Difficulty keeping appointments/ no shows
Fear/ Concerns re: abuse
At risk of eviction / Low Income
Concerns of general safety
Recent loss of spouse

ED visit in last 3 months
Taking more than 3 medications
Fallen in last 3 months
New medical diagnosis < 3 month
Chronic illness/ pain monitoring
>10 lbs weight loss <2 month
Recent change in mood/ behavior
Recent change in cognition/ memory

If checked, please describe here:



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Does the client currently have any of the following services? If yes, please describe below.

CCAC Home Support G.P.C.S.O Day Hospital/ Program G.A.O.T Other

If checked, please describe here:

Infectious Diseases – Check all that apply.

HIV HEP C C DIFF MRSA TB VRE

Medical Conditions/Diagnosis:

1. _____	2. _____
3. _____	4. _____
5. _____	6. _____
7. _____	8. _____

Current Medications / Prescribed by:

1. _____	2. _____
3. _____	4. _____
5. _____	6. _____
7. _____	8. _____

PLEASE ATTACH A COPY OF ANY RECENT DISCHARGE REPORTS OR COMPLETED ASSESSMENTS

Safety Precautions – Does the client have a history of:

Aggressive Behavior Substance Abuse Bed Bugs Pets in Home Hoarding

Please contact Central Intake to further discuss any safety concerns you may have regarding the client

If checked, please describe here:

Expectations from PCO/Goals of Referral Source: