COMMUNITY SUPPORT SERVICES

REFERRAL FORM

A - Client Demographics (Attach label here if available)

First Name:

Last Name:

Gender:

DOB:

Address:

City:

Postal Code:

Phone:

Preferred Language: ☐ En ☐ Fr ☐ Other (specify):

B - Alternate Contact Person (optional)

Name:

Relationship to Client:

Address:

Phone:

Alt Phone:

Conduct call back with: ☐ Client ☐ Alternate Contact ☐ Referrer (below)

C - Referrer Contact Information

Name:

Organization:

Phone #: ( ) - x

Fax #: ( ) -

Follow-up with me via: ☐ Phone/Voicemail ☐ Fax ☐ None

Referrer Role

☐ Physician
☐ CCAC Hospital CC
☐ CCAC Community CC
☐ Social Worker
☐ Other (specify):
☐ Nurse Practitioner
☐ Nurse
☐ GEM nurse
☐ OT
☐ PT
☐ CSS

D - Reason for Referring Client

Comments: *(e.g. reason for referral, service needs, urgency rationale, financial concerns, condition, etc...)*

E - Request Client Services *(Please copy onto 'Community Support Services Handout')*

☐ *Meals on Wheels*
☐ *Group Dining*
☐ *Caregiver Support*
☐ *Housekeeping*
☐ *Transportation*
☐ *Shopping*
☐ *Home Maintenance*
☐ *Telephone Reassurance*
☐ *Friendly Visiting*
☐ *Gentle Exercise*
☐ *Senior Community Centre*
☐ *Adult Day Program*
☐ *Alzheimer/Dementia Day Program*
☐ *Alzheimer/Dementia Services (First Link®)*
☐ *Blind/Low Vision Rehabilitation*
☐ *Hearing Loss/Deaf Support*
☐ *Overnight Stay Respite*
☐ *Acquired/Traumatic Brain Injury Supports*
☐ *Palliative Support and Wellness*
☐ *Spinal Cord Injury Supports*
☐ *Attendant Services*

Call Back Date and Time *(Please copy onto 'Community Support Services Handout')*

Call Back Date:

Call Back Time: ☐ 8:30-10 AM ☐ 10-12 PM ☐ 12-2 PM ☐ 2-4:30 PM

Request an Agency *(optional – normally the appropriate provider will be found by the CSS Resource Centre)*

Agency name(s):

F - Attachment Information

Description of Attachment

Pages