

Referral form for *The Friends Programs/Services*

Referral source (please check off as appropriate):

Date of referral:

- | | | |
|------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Self | <input type="checkbox"/> CCAC | <input type="checkbox"/> TCC/Discharge Planner |
| <input type="checkbox"/> Family | <input type="checkbox"/> GEM Nurse | <input type="checkbox"/> Internal |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Other _____ | <input type="checkbox"/> HAL |

Client Name: _____

Valid Ontario Health Card: Yes No

Address: _____ Postal Code: _____

Telephone: _____ Work: _____ Cell: _____

Email address: _____

Contact Person: _____ (if different from Client name)

Telephone: _____ Work: _____ Cell: _____

Case Manager: _____

Programs Requested

- | | |
|--|---|
| <input type="checkbox"/> Accessible Housing (24 Hour Attendant Care) | <input type="checkbox"/> Adult Day Away Program |
| <input type="checkbox"/> Assisted Living for Seniors | <input type="checkbox"/> Support Groups/Caregiver Support Program |
| <input type="checkbox"/> Senior's Homemaking | <input type="checkbox"/> Respite Program |
| <input type="checkbox"/> Outreach (Attendant Care) | |

Description of services requested: (for example; assistance with personal hygiene, meal preparation, medications, light housekeeping, social interaction, supervision, education, in home caregiver relief)

Other agency/service providers (private/government/other): _____

Referrals can be emailed to info@thefriends.on.ca or faxed to: 705-746-8139

I, _____, give my consent and am willing to release information and share assessment data between the referral source noted above and the Friends.

Signature of Client/Substitute Decision Maker/Power of Attorney

FOR OFFICE USE ONLY	
Referral Received by: _____	Date: _____
Referral Directed to: _____	Date: _____