Referral Form for *The Friends* Programs/Services

Referral source (please check off as appropriate):

- ☐ Self
- ☐ Family
- ☐ Physician
- ☐ TCC/Discharge Planner
- ☐ Home & Community Care Support Services
- ☐ GEM Nurse
- ☐ Internal

Date of referral:

- ☐ HAL
- ☐ Other _____

Client Name: _____ Date of Birth: _____

Health Card Number: _____ Version Code:_____ Diagnosis: _____

Address: _____ City/Town _____ Postal Code: _____

Telephone: _____ Work: _____ Cell: _____

Email address: _____

Contact Person/Caregiver: _____ (if different from Client name)

Telephone: _____ Work: _____ Cell: _____

Care Coordinator:

Programs Requested

- ☐ Accessible Housing (24 Hour Attendant Care)
- ☐ Assisted Living for Seniors
- ☐ Senior's Homemaking
- ☐ Outreach (Attendant Care)
- ☐ Post Stroke (Transitional Care)
- ☐ Low Acuity
- ☐ Transitional Respite Program
- ☐ Alzheimer Overnight Respite Program
- ☐ Caregiver Respite
- ☐ Caregiver Support Program
- ☐ Adult Day Program

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

Referral Completed by:

Phone: _____

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FOR OFFICE USE ONLY

Referral Received by: _____ Entered: _____

Referral Directed to: _____ Date: _____