

Referral form for *The Friends Programs/Services*

Referral source (please check off as appropriate):

Date of referral: _____

- Self
- Family
- Physician

- LHIN Home & Community Care
- GEM Nurse
- Other _____

- TCC/Discharge Planner
- Internal
- HAL

Client Name: _____

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

Address: _____ Postal Code: _____

Telephone: _____ Work: _____ Cell: _____

Email address: _____

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

Telephone: _____ Work: _____ Cell: _____

Care Coordinator: _____

Programs Requested

- | | |
|--|--|
| <input type="checkbox"/> Accessible Housing (24 Hour Attendant Care) | <input type="checkbox"/> Transitional Respite Program |
| <input type="checkbox"/> Assisted Living for Seniors | <input type="checkbox"/> Alzheimer Overnight Respite Program |
| <input type="checkbox"/> Senior's Homemaking | <input type="checkbox"/> Caregiver Respite |
| <input type="checkbox"/> Outreach (Attendant Care) | <input type="checkbox"/> Caregiver Support Program |
| <input type="checkbox"/> Post Stroke (Transitional Care) | <input type="checkbox"/> Adult Day Program |
| <input type="checkbox"/> Low Acuity | |

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: _____	CIMS: _____
Referral Directed to: _____	Date: _____