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: _____ 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: _____

*Rev 03 2019*

**FOR OFFICE USE ONLY**

Referral Received by: _____ CIMS: _____

Referral Directed to: _____ Date: _____