Early Resource Nurse Referral
Fax: 705-450-6600

Collaborative Care Algoma

Patient Information *(may place demographic label here)*

Name: **DOB**:

Address: **Phone**:

Health Card #:

Person to Contact

☐ Patient

☐ Substitute Decision Maker(s): Phone:

☐ Other:

Relationship: Phone:

Medical Information *(if applicable)*

Diagnosis:

Additional Notes:

Reason for Referral *(Check all that apply)*

☐ **Advance Care Planning for a Capable Healthy Person**
(Assist with identification of Substitute Decision Maker(s) (SDM), explore values, beliefs & quality of life, worries & fears, trade offs, and nearing the end of life)

☐ **Advance Care Planning for a Capable Person with Serious Illness**
(Assist with identification of Substitute Decision Maker(s) (SDM), explore illness understanding, values, beliefs & quality of life, worries & fears, trade offs, and nearing the end of life)

☐ **End-of-Life Planning for Capable Person or Incapable Person's SDM(s)**
(Explore end-of-life care options and discuss resuscitation status)
**If expressed interest in ARCH paperwork completion-please complete the ARCH Intake Referral form.*

☐ **Healthcare System Navigation**
(Provide ongoing support to connect with services and assist with coordination of care.)

By completing this form, you confirm that you have explained the purpose of this referral to the patient, or their SDM(s) if the patient is mentally incapable, and that they wish to be contacted by an Early Resource Nurse.

Referred by: **Signature:** **Date:**

info@collaborativecarealgoma.ca ❖ 705-942-8348