



"Rebuilding a life...  
Renewing a dream"

## WENDAT SERVICES FOR SENIORS

### Psychogeriatric Services Program Referral Form – TRANSITION SERVICE

**Referred by:**  
**Organization name and address:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Date of Referral:** \_\_\_\_\_

**Referral Contact:**

**Name:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

**Fax #** \_\_\_\_\_

#### Client Information:

Client name: \_\_\_\_\_

DOB: \_\_\_\_\_ HC# \_\_\_\_\_

Marital

Address: \_\_\_\_\_

Status \_\_\_\_\_

Gender: Man  Women

I identify as \_\_\_\_\_

Phone: \_\_\_\_\_

Language first spoken \_\_\_\_\_

Preferred Language of communication \_\_\_\_\_

Aboriginal origin: Y  N  U/K

Veteran: Y  N  U/K

Cultural Needs: Y  N  U/K  specify \_\_\_\_\_

Spiritual Needs: Y  N  U/K  specify \_\_\_\_\_

Is this person Capable for:

Personal Care/Treatment: Y  N  U/K

Property: Y  N  U/K

Contact Person

Contact Person

\_\_\_\_\_  
(Name and relationship))

\_\_\_\_\_  
(Name and relationship))

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Telephone)

\_\_\_\_\_  
(Telephone)

Alternate Contact Person: \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Telephone)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Relationship)

Are there any outstanding legal issues? (Please elaborate) \_\_\_\_\_



Formal Supports/Services Involved:

- CCAC
  - Alzheimer’s
  - Day Out
  - Homemaker
  - CMHA
  - Waypoint
  - ACTT
  - COAST
  - CNIB
  - Respite
  - Psychogeriatric Resources Consultants
  - Rehab
  - Wendat Internal Referral
  - No Supports
  - Compliance
  - Other Community Engagement: \_\_\_\_\_
- 

Informal Supports Involved:

- Family
  - Friends
  - Neighbors
  - Volunteers
  - No Supports
  - Other \_\_\_\_\_
- 

Present accommodation:

- Private house/apt
- Retirement Home
- Long Term Care
- Homes for Special Care
- Ontario Housing
- Supportive Housing
- Group Home
- Mental Health Unit
- Continuing Complex Care
- General Hosp
- Homeless
- Hostel/Shelter

Concerns related to housing situation: \_\_\_\_\_

Living Arrangement:

- Alone
- With Parents
- With Children
- With Spouse
- With Friend
- With Other Family
- Non-related caregiver

Highest level of Education attained:

- No formal Schooling
- Some Elementary/Junior High
- Elementary/Junior High
- Some Secondary/High School
- Secondary/High School
- Some College/University
- Community College
- University
- Other: \_\_\_\_\_
- Unknown or Service Recipient Declined

Primary Income Source:

- Employment
- Employment Insurance
- Pension
- ODSP
- Social Assistance
- Disability Assistance
- Family
- No Source of Income
- Other
- Unknown or Service Recipient Declined

Is the person aware of this referral?  Y  N  U/K \_

Has consent been obtained?  Y  N  U/K \_

**Documents included in Referral Package:**

- Power of Attorney (a copy if client is not capable to provide consent)
- Consent for Disclosure of Personal Health Information (Verbal or Written)
- History/consults – Medical, Psychiatric, Social, Neurological
- OT/PT Assessments
- Cognitive testing and results
- Recent:
  - Lab
  - MARS
  - X-ray, Diagnostic imaging (CT, MRI, etc)

Thank you for assisting us in assuring that the service we provide is effective, efficient and appropriate to the needs of our mutual client as well as their formal and informal support system.

**Please forward the completed referral form to:**

Zina Thomson, Program Supervisor

**Wendat Community Programs**

**44 Dufferin St. Penetanguishene, ONT L9M 1H4**

**FAX: (705) 355-1026**

**WEBSITE: [www.wendatprograms.com](http://www.wendatprograms.com)**

**The Program Manager can also be reached by telephone**

**Monday to Thursday 9AM - 5PM at 705-355-1022 ext 228**

OFFICE USE ONLY

Date referral received: \_\_\_\_\_ Date Intake screen: \_\_\_\_\_

Intake Outcome: \_\_\_\_\_ Service Assignment date: \_\_\_\_\_

Assigned to: \_\_\_\_\_