SENIORS COMMUNITY SUPPORT PROGRAMS

REFERRAL FORM

Referred by:
Organization name and address:
____
____
____

Date of Referral: ______________
Referral Contact:
Name: _______________
Phone #: _____________
Fax # ______________

Client Information:

Client name: ____________________

DOB: ___________ HC# _____________

Address: ________________________
____

Marital Status ________ Gender: M □ F □ Other □

Phone: ______________________

Language at birth: ____________________
Present language(s) 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 □

Contact Person

____
(Name and relationship))

____
(Address)

____
(Telephone)

Property: Y □ N □ U/K □

Contact Person

____
(Name and relationship)

____
(Address)

____
(Telephone)

Alternate Contact Person: _____________________________ (Name)
___________________ (Telephone)

____ (Address)
___________________ (Relationship)

Are there any outstanding legal issues? (Please elaborate) ______________________________
____

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History of Hospitalizations:

# of in-patient admissions within past year? _____

# of ER visits within past year? _____

Diagnoses: ____

____

Family Physician/Psychiatrist:

____
(Name)

______________________________ ______________________________
(Address) (Telephone)

Medications: (Prescribed): **Allergies:** ______________________________

____
____
____
____

OTC: Y □ N □ U/K □ ____
Herbal: Y □ N □ U/K □ ____

Reason for Referral :

Program requested:	Areas of concern:	
□Social and Congregate Dining	□ Falls	□ Financial
□ Day Programming	□ Caregiver burnout	□ Nutrition
□ Assisted Living Service	□ Disease management	□ Neglect
	□ Substance Use	□ Housekeeping
Additional services Requested:	□ Safety in Home	□ Memory changes
	□ Medication management	□ Loss
□ Medication/chronic disease monitoring	□ Social Isolation/activation	□ Health Teaching
□ Culturally specific social integration	□ Behavioural changes	
	□ Pets	
______________________________	______________________________	
______________________________	______________________________	
______________________________	______________________________	
	______________________________	

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Formal Supports/Services Involved:

□ CCAC □ Alzheimer's □ Day Out □ Private Homemaker
□ CMHA □ MHCP □ CLH
□ CNIB □ Respite □ Rehab □ Wendat
□ Other ____
____

Informal Supports Involved:

□ Family □ Friends □ Neighbors □ Volunteers
□ Other ____
____

Present accommodation:

☐ Private house/apt □ Retirement Home □ Long Term Care
□ HSC □ Ontario Housing □ Supportive Housing
□ Group Home □ Psych Hosp □ Chronic Care
□ General Hosp □ Homeless □ Hostel/Shelter
□ Other ____
____

Living Arrangement:

☐ Alone □ Spouse/Partner □ Spouse/Partner and Others
□ Children □ Relatives □ Non-Relatives

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:

☐ OAS Pension ☐ OAS Supplement ☐ CPP ☐ Disability Assistance
☐ Family ☐ ODSP ☐ 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 _________________

Please forward the completed application to:
Program Supervisor, Seniors Community Support Programs Wendat Community Programs
44 Dufferin St. Penetanguishene ON L9M 1H4
FAX: (705) 355-1026
WEBSITE : www.wendatprograms.com
Monday to Friday 9AM - 5PM at 705-355-1022 Ext: 226