



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

**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: _____