

SENIORS COMMUNITY SUPPORT PROGRAMS

REFERRAL FORM

(Social & Congregate Dining, Day Program, Assisted Living Services)

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 ☐

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) _____

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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 :

<p><u>Program requested:</u></p> <p><input type="checkbox"/> Social and Congregate Dining <input type="checkbox"/> Day Programming <input type="checkbox"/> Assisted Living Service</p> <p><u>Additional services Requested:</u></p> <p><input type="checkbox"/> Medication/chronic disease monitoring <input type="checkbox"/> Culturally specific social integration</p> <p>_____ _____ _____</p>	<p><u>Areas of concern:</u></p> <table border="0"><tr><td><input type="checkbox"/> Falls</td><td><input type="checkbox"/> Financial</td></tr><tr><td><input type="checkbox"/> Caregiver burnout</td><td><input type="checkbox"/> Nutrition</td></tr><tr><td><input type="checkbox"/> Disease management</td><td><input type="checkbox"/> Neglect</td></tr><tr><td><input type="checkbox"/> Substance Use</td><td><input type="checkbox"/> Housekeeping</td></tr><tr><td><input type="checkbox"/> Safety in Home</td><td><input type="checkbox"/> Memory changes</td></tr><tr><td><input type="checkbox"/> Medication management</td><td><input type="checkbox"/> Loss</td></tr><tr><td><input type="checkbox"/> Social Isolation/activation</td><td><input type="checkbox"/> Health Teaching</td></tr><tr><td><input type="checkbox"/> Behavioural changes</td><td></td></tr><tr><td><input type="checkbox"/> Pets</td><td></td></tr></table> <p>_____ _____ _____</p>	<input type="checkbox"/> Falls	<input type="checkbox"/> Financial	<input type="checkbox"/> Caregiver burnout	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Disease management	<input type="checkbox"/> Neglect	<input type="checkbox"/> Substance Use	<input type="checkbox"/> Housekeeping	<input type="checkbox"/> Safety in Home	<input type="checkbox"/> Memory changes	<input type="checkbox"/> Medication management	<input type="checkbox"/> Loss	<input type="checkbox"/> Social Isolation/activation	<input type="checkbox"/> Health Teaching	<input type="checkbox"/> Behavioural changes		<input type="checkbox"/> Pets	
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Formal Supports/Services Involved:

- | | | | |
|--------------------------------------|--------------------------------------|----------------------------------|--|
| <input type="checkbox"/> CCAC | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Day Out | <input type="checkbox"/> Private Homemaker |
| <input type="checkbox"/> CMHA | <input type="checkbox"/> MHCP | <input type="checkbox"/> CLH | |
| <input type="checkbox"/> CNIB | <input type="checkbox"/> Respite | <input type="checkbox"/> Rehab | <input type="checkbox"/> Wendat |
| <input type="checkbox"/> Other _____ | | | |
-

Informal Supports Involved:

- | | | | |
|--------------------------------------|----------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Family | <input type="checkbox"/> Friends | <input type="checkbox"/> Neighbors | <input type="checkbox"/> Volunteers |
| <input type="checkbox"/> Other _____ | | | |
-

Present accommodation:

- | | | |
|--|--|---|
| <input type="checkbox"/> Private house/apt | <input type="checkbox"/> Retirement Home | <input type="checkbox"/> Long Term Care |
| <input type="checkbox"/> HSC | <input type="checkbox"/> Ontario Housing | <input type="checkbox"/> Supportive Housing |
| <input type="checkbox"/> Group Home | <input type="checkbox"/> Psych Hosp | <input type="checkbox"/> Chronic Care |
| <input type="checkbox"/> General Hosp | <input type="checkbox"/> Homeless | <input type="checkbox"/> Hostel/Shelter |
| <input type="checkbox"/> Other _____ | | |
-

Living Arrangement:

- | | | |
|-----------------------------------|---|--|
| <input type="checkbox"/> Alone | <input type="checkbox"/> Spouse/Partner | <input type="checkbox"/> Spouse/Partner and Others |
| <input type="checkbox"/> Children | <input type="checkbox"/> Relatives | <input type="checkbox"/> Non-Relatives |

Highest level of Education attained:

- | | | |
|--|--|--|
| <input type="checkbox"/> No formal Schooling | <input type="checkbox"/> Some Elementary/Junior High | <input type="checkbox"/> Elementary/Junior High |
| <input type="checkbox"/> Some Secondary/High School | <input type="checkbox"/> Secondary/High School | <input type="checkbox"/> Some College/University |
| <input type="checkbox"/> Community College | <input type="checkbox"/> University | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Unknown or Service Recipient Declined | | |

Primary Income Source:

- | | | | | |
|---|--|------------------------------|--|---------------------------------|
| <input type="checkbox"/> OAS Pension | <input type="checkbox"/> OAS Supplement | <input type="checkbox"/> CPP | <input type="checkbox"/> Disability Assistance | <input type="checkbox"/> Family |
| <input type="checkbox"/> ODSP | <input type="checkbox"/> No Source of Income | | | |
| <input type="checkbox"/> Other <input type="checkbox"/> 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:

Director Seniors Services, 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: 2228