HOME AND COMMUNITY CARE SUPPORT SERVICES
Toronto Central

250 Dundas Street West, Suite 305, Toronto, ON
M5T 2Z5 Tel: 416-506-9888 | 1-866-243-0061
www.healthcareathome.ca/torontocentral

REFERRAL FORM FOR HOME AND COMMUNITY CARE SERVICES

FOR RM&R DOWNTIME USE ONLY

PLEASE FAX COMPLETED REFERRAL FORM TO HOME AND COMMUNITY CARE SUPPORT SERVICES TORONTO CENTRAL 416-217-1168

* PLEASE PRINT CLEARLY *

CLIENT INFORMATION

LAST NAME: _____ **FIRST NAME:** _____

HEALTH CARD #: _____**VC:**_____ **DATE OF BIRTH: DD** _____ **MM** _____ **YYYY**_____

ADDRESS: _____ **APT#:**_____**ENTRY CODE:** _____

CITY:_____ **PROVINCE:** _____ **POSTAL CODE:**_____

PRIMARY TELEPHONE #: (_____)_____**ALTERNATE:** (_____)_____

PREFERRED LANGUAGE: _____

CLIENT'S PRIMARY CONTACT INFORMATION

LAST NAME: _____ **FIRST NAME:** _____

RELATIONSHIP TO CLIENT: _____ **PRIMARY TELEPHONE #:**(_____)_____

ALTERNATE: (_____)_____ **PREFERRED LANGUAGE:** _____

Reason for Home and Community Care Support Services Toronto Central Service Referral:

Has the client fallen within the last 30 days?: Yes ☐ No ☐
Was the client in hospital within the last 30 days?: **Yes** ☐ **No** ☐
Is the Client/POA/SDM aware of this referral: **Yes** ☐ **No** ☐

REFERRAL SOURCE

HOSPITAL: _____ **CURRENT LOCATION:** ☐ **IP** ☐ **ED** ☐ **OP** ☐ **OP-CHEMO**

ADDRESS: _____

CITY:_____ **PROVINCE:** _____ **POSTAL CODE:**_____

REFERRING: ☐ **MOST RESPONSIBLE PERSON (MRP):** ☐

PROFESSIONAL DESIGNATION: _____

NAME: _____

TELEPHONE: (_____)_____ **EXTENSION:**_____ **FAX:** (_____)_____

SIGNATURE: **DATE:**

CONFIDENTIAL WHEN COMPLETED. IF YOU HAVE THIS FORM IN ERROR PLEASE DO NOT COPY OR DISPOSE OF. CONTACT 416-506-9888 AND WE WILL MAKE ARRANGEMENTS TO COLLECT IT.

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LAST NAME: _____ FIRST NAME: _____

HEALTH CARD #: _____ VC:_____

MEDICAL INFORMATION		
PRIMARY DIAGNOSIS		
SECONDARY DIAGNOSIS		
ALLERGIES		
RELEVANT MEDICAL HISTORY/ HOSPITAL COURSE		
MEDICATION	**Name: _____Dosage:_____ Frequency: _____ Route: _____Duration: _____** **Name: _____Dosage: ____ Frequency: _____ Route: _____Duration: _____** **Name: _____ Dosage: _____Frequency: _____ Route: _____Duration: _____** **Other:**	
MOBILITY	**Ambulatory: ☐ Yes ☐ No** **Client uses: ☐ Wheelchair ☐ Walker ☐ Cane ☐ Scooter** **Other:_____**	
SERVICES REQUESTED	***Mandatory Information*** 1. Identify reason/ need for each service selected 2. Provide Treatment Orders and Start Date as applicable 3. Include an Estimated Date of Discharge 4. For Nursing Service - Client will receive assessment and treatment at one of the HCCSS Nursing Clinics (in-home nursing arranged by exception only) 5. Fax referral AND relevant documents together (i.e. script, palliative care referral form, allied health reports)	
☐ **Nursing** (including Nursing Clinics) ☐ **Personal Care** (bathing/dressing) ☐ **Dietician/Nutrition** ☐ **Occupational Therapy** ☐ **Physiotherapy** ☐ **Speech Language Pathology** ☐ **Social Work** ☐ **LTCH Assessment** ☐ **Case Management** ☐ **Community Linking** (i.e. homemaking)		
☐ **Palliative Care**	**Prognosis: _____ Palliative Performance Scale (PPS): _____%**	
☐ **Rapid Response Nursing**	☐ **CHF** ☐ **COPD**	
PHYSICIAN/NP NAME:		**OHIP BILLING CODE:_____ CPSO/CNO#:_____**
PHYSICIAN/NP SIGNATURE:		**DATE:**

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