Casey House Services Referral Form

Please fill out the form as completely and accurately as possible, and include all relevant medical notes and information to avoid delays in the referral review process.

Fax completed referral forms to: 416-929-8849
Questions? Please contact referral@caseyhouse.ca or dial 416-962-4040 ext. 8000.

DATE OF REQUEST (YYYY-MM-DD):	

PROGRAM AREA

◯ Inpatient General ◯ Inpatient Respite ◯ Day Health Program

For more information on program areas please see: https://www.caseyhouse.com/accessing-care/refer-a-client/

HIV STATUS:	◯ Positive ◯ Negative
COVID VACCINATION RECORD:	☐ Vaccinated ☐ Unvaccinated ☐ Unknown Status If **vaccinated**, please note vaccination dates below
DATE OF 1st DOSE:	DATE OF 2nd DOSE: DATE OF 3rd DOSE:

CLIENT CONTACT INFORMATION

First Name:	Last Name:
Preferred Name:	
Pronouns: ◯ she/her ◯ he/him ◯ them/they ◉ Not Listed:	
Date of Birth (yyyy-mm-dd):	
OHIP Number: if **NO** OHIP, please state reason:	Version Code:
Address:	
Phone Number:	Client's Email:

☐ Please check this box if you authorize to have the client included in communications

REFERRING AGENT INFORMATION (IF APPLICABLE)

First Name:	Last Name:

RELATIONSHIP TO CLIENT: (PLEASE PUT IN YOUR ORGANIZATION NAME/RELATIONSHIP)

◯ GP/NP:
◯ Community Provider:
◯ Specialist:
◯ Not Listed:
◯ Family Member/ Partner/ POA:
◯ Social Worker/ Case Manager:
◯ Registered Nurse:

REFERRING AGENT INFORMATION (IF APPLICABLE)	
Organization (if applicable):	
Address:	
Phone Number:	Email:

REASON FOR REFERRAL (PLEASE SELECT ALL THAT APPLY)	
A. PALLIATIVE NEEDS (PLEASE ELABORATE ON COMMENTS SECTION)	
☐ Palliative ☐ Medical Assistance in Dying (MAiD) ☐ End-of-Life Care ☐ Pain Management ☐ Symptom Management ☐ Not Listed:	Additional Comments/ Information:
B. MEDICAL NEEDS (PLEASE ELABORATE ON COMMENTS SECTION)	
☐ IV Therapy ☐ Chemo Support ☐ Acute Infection ☐ Complex Wound Care ☐ Post-Op Support ☐ Not Listed:	Additional Comments/ Information:
C. MENTAL HEALTH NEEDS (PLEASE ELABORATE ON COMMENTS SECTION)	
☐ Mental Health Symptoms ☐ Medication Support ☐ Substance Use Support ☐ Not Listed:	Additional Comments/ Information:

D. RESPITE (PLEASE ELABORATE ON COMMENTS SECTION)	
☐ Increase Weight/Strength ☐ Caregiver Respite ☐ Not Listed:	Additional Comments/ Information:

HEALTH GOALS FOR ADMISSION (PLEASE STATE THE INTENDED OUTCOMES FOR ADMISSION)

CURRENT MEDICATIONS

Please attach a current medication list from your pharmacy or health provider, or please provide **Pharmacy** or **Health Provider** Contact Information below:

Pharmacy Name, Location	Contact Number	Health Provider Name, Location	Contact Number

SUPPLEMENTARY ATTACHMENTS

Please attach to this form any recent medical or clinic notes as well as any relevant information you can provide about the client's health history. Incomplete forms can result in delays in the referral review process