For office use only :

HOUSE CALLS REFERRAL FORM

HouseCalls
Interdisciplinary healthcare for homebound seniors

Fax to: 416-481-2590

Questions: 416-481-5099

Please complete this form and ensure that all information is filled out completely and correctly. Missing information or errors may result in a prolonged assessment period. Thank you.

1) CHECK MARK THE REFERRAL'S LEVEL OF URGENCY: ☐ Routine ☐ Urgent

Date of referral:

If you checked "Urgent" above, then please provide further explanation in the field below:

2) PROVIDE INFORMATION ABOUT REFERRAL SOURCE:

Check mark the source of the referral to House Calls:

- ☐ Community Care and Access Centre (CCAC)
- ☐ Community support service agency
- ☐ Hospital emergency department
- ☐ Hospital inpatient department
- ☐ Intake
- ☐ Other

Referrer's name: Contact Number: Ext:

Email:

Confirm that you have attached one of the items below to this referral:

- ☐ Consultation notes
- ☐ Demographic profile
- ☐ Recent discharge summary
- ☐ Lab results
- ☐ Medication profile

3) PROVIDE CLIENT'S CONTACT INFORMATION:

Name: Date of Birth: Day Month Year

Phone Number: Address:

City: Province: Postal Code:

OHIP Number and Version Code:

4) CLIENT ELIGIBILITY:

Has the client been informed about their referral to House Calls and does the client consent to transfer their care to House Calls? ☐ Yes ☐ No

Is the client 65 years of age or older? ☐ Yes ☐ No

Does the client live in the House Calls catchment area M4G, M4N, M4P, M4R, M4S, M4W, M4T, M4V, M4X, M4Y, M5B, M5G, M5M, M5N, M5P, M5R, M5S, M5T, M6E, M6H, M6C or M6G

YES ☐ NO ☐

Please identify the nearest major intersection to the client's home

What is the client's primary diagnosis? Provide a brief medical history:

Does the client have difficulty accessing a family physician because of physical, cognitive or psychiatric impairments? ☐ Yes ☐ No

If "Yes" above, then check mark the impairments that apply and explain:

☐ Physical

☐ Cognitive

☐ Psychiatric

Safety risks (e.g. bedbugs, communicable diseases, physical aggression, clutter, etc.

Where patient care needs exceed the scope of home-based primary care, complex continuing care might be a more appropriate care option. The House Calls team does not have expertise in managing mechanical ventilation, tracheostomies and feeding tubes. We do not accept patients that are actively in need of palliative care at the time of enrollment.

5) CLIENT INFORMATION:

Has the client visited the hospital (ED or other) in the previous three months? ☐ Yes ☐ No

Has the client fallen within the previous three months? ☐ Yes ☐ No

Does the client have a primary care provider? ☐ Yes ☐ No

If you check marked "Yes", then provide the primary care provider's information:

Name: Phone Number: Ext:

Has the client visited their family physician within the previous six months? ☐ Yes ☐ No

6) PROVIDE INFORMATION ABOUT THE CLIENT'S CAREGIVER:

Does the client have a caregiver? Check mark one: ☐ Yes ☐ No

If yes, caregiver's name? _____ Comments: _____

7) SOCIAL AND FINANCIAL INFORMATION:

Marital Status: _____ Languages Spoken: _____

Does the client live alone? ☐ Yes ☐ No

Does the client have housing, social or financial issues? ☐ Yes ☐ No

Does the client use assistive devices, such as a walker, wheelchair, etc.? ☐ Yes ☐ No

Comments: _____

8) CONTACT THE CLIENT DIRECTLY: ☐ Yes ☐ No

If you check marked “No” above, then provide information about the client’s contact person:

Name: _____ Phone Number: _____

Relationship to the client: _____

9) PROVIDE INFORMATION ABOUT CCAC INVOLVEMENT: ☐ Yes ☐ No

If you check marked "Yes" above, then provide further information:

Name of Care Coordinator: _____ Phone Number: _____

Email: _____ Ext: _____

Provide details above CCAC services that the client is currently receiving: _____

THANK YOU FOR COMPLETING THIS FORM AND FAXING IT TO 416-481-2590

SPRINT Senior Care

Ontario
Toronto Central Local Health Integration Network

VHA Home HealthCare
Creating More Independence

Sinai Health System
HEALTHY AGEING AND GERIATRICS