

For office use only :



Interdisciplinary healthcare for homebound seniors

HOUSE CALLS REFERRAL FORM

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) Hospital inpatient department
 Community support service agency Intake
 Hospital emergency department Other

Referrer's name: Contact Number: Ext:

Email:

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

Consultation notes Lab results
 Demographic profile Medication profile
 Recent discharge summary

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 age-related physical, cognitive or social frailties? Yes No

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

Physical

Cognitive

Social

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

