



Continuing Care Social Work Referral Form

The Pas & Area
Phone (204) 627-6467
Fax (204) 627-8285

Thompson & Area
Phone (204) 778-1571
Fax (204) 778-1541

Client Name _____ Client Contact # _____

Client Address _____

Date of Birth _____ Date of Referral _____
dd/mmm/yyyy dd/mmm/yyyy

PHIN Number _____

Client is aware of referral Yes No

Referred by (include Department) _____

Issue/Concern (Check all that apply)

- Housing Support Client Support Client Planning Advanced Care Plan
- Advocacy Financial Concerns Conflict Resolution Substance Abuse
- Elder Abuse Palliative Support Dignity Therapy Grief Support
- Family/Caregiver Counselling
- Provide Long-Term Care Information (POA, Public Trustee, Panel Process etc.)
- Assist Client in Navigation of Systems/Agencies/Link to Community Resources

Diagnoses _____

Other Health Concerns _____

Presenting Issues _____

check if f/u continued on reverse

Social Worker _____ Date _____
signature dd/mmm/yyyy