NORTHERN HEALTH REGION

HOME CARE REFERRAL FORM

Fax to:
☐Thompson 204-778-1571
☐The Pas 204-627-8285
☐Flin Flon 204-687-7143

Client:_____

_____

DOB (dd/mmm/yyyy): _____

HRN / MHSC: _____

PHIN #: _____

Client Label

ADMISSION DATE	DD/MMM/YYYY	DISCHARGE DATE	DD/MMM/YYYY
SERVICE(S) REQUESTED			
SERVICE ADDRESS (IF DIFFERENT FROM ABOVE)		PHONE (home) ( ) PHONE (alternate) ( )	
CLIENT'S PRIMARY CONTACT NAME			
RELATIONSHIP		PHONE (home) ( )	
LANGUAGES SPOKEN ☐ ENGLISH ☐ OTHER (Specify)		UNDERSTOOD ☐ ENGLISH ☐ OTHER (Specify)	
MEDICAL DIAGNOSIS		ALLERGIES	
TREATMENT/MEDICAL ORDERS		☐ See attached if Applicable	
MEDICATION RECONCILIATION Name/Dose/Route/Frequency/Duration		☐ See attached if Applicable	
LIST OTHER PROGRAMS/SERVICES INVOLVED (attach list if more room needed)	Phone ( )	Fax ( )	

LIVING ARRANGEMENTS ☐ Alone ☐ With Relatives ☐ With Others	SAFETY (e.g. pets, smoking, etc.) COMMUNICATION Vision Impairment……☐ YES ☐ NO Hearing Impairment……☐ YES ☐ NO Speech Impairment…….☐ YES ☐ NO	DAILY LIVING Is a client/family member able to Prepare Meals……☐ YES ☐ NO Do the Shopping……☐ YES ☐ NO Do the Housekeeping……☐ YES ☐ NO Manage Personal Care……..☐ YES ☐ NO
FAMILY SUPPORT AVAILABLE ☐ YES ☐ NO MOBILITY ☐ Independent ☐ Independent with Equipment ☐ Needs Assist ☐ Wheelchair Independent ☐ Other	CONTINENCE ☐ Completely Continent ☐ Incontinent Urine ☐ Indwelling Catheter ☐ Incontinent Feces ☐ Other	COGNITION AND BEHAVIOURAL ISSUES Alert and Oriented……☐ YES ☐ NO Intact Memory……☐ YES ☐ NO Anxiety……☐ YES ☐ NO Depressed……☐ YES ☐ NO ☐ Other

COMMENTS		
PHYSICIAN'S NAME AND ADDRESS	Phone ( )	Fax ( )
NAME OF REFERRAL SOURCE (printed)	Phone ( )	Fax ( )
SIGNATURE AND DESIGNATION	DATE DD/MMM/YYYY	