SHERBOURNE Health Centre

USE BLACK INK ONLY

Date: _____ **Date Received:** _____
(Completed by Infirmary Staff)

INFIRMARY PROGRAM REFERRAL FORM[1]

CLIENT INFORMATION

Client Name:_____ _____
LAST NAME FIRST NAME (PREFERRED NAME)

DOB: _____ **AGE:** _____
DD / MM / YYYY

OHIP#: _____**VC**:_____ Other: _____

Medication coverage: _____

Gender: ☐**M** ☐**F** ☐**Transgender** ☐**Other:**_____ **Preferred Pronoun**:_____

Client Contact #:_____

Current living situation: (please check the appropriate box)

- ☐ Homeless- (Couch Surf)
- ☐ Homeless- (Rough)
- ☐ Homeless- (shelter)
- ☐ Housed
- ☐ Supportive Housing

If Housed, Address:_____

REASON FOR REFERRAL:

_____

_____

Primary Medical Diagnosis: _____

SOURCE OF REFERRAL

Referee Name:_____ **Title:** _____

Contact:_____ **ext.** _____ **Pager/Cell:**_____

(please check the appropriate box)

- ☐ **COMMUNITY AGENCY:** _____
- ☐ **HOSPITAL:** _____ **DEPT:** _____
- ☐ **SHC: PROGRAM:** _____
- ☐ **SELF**

_____

[1] Revised March 2017

333 Sherbourne Street, 3rd Floor, Toronto, ON M5A 2S5
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***Expected Outcome/Change &/or Improvement From Short-Term Stay:**

_____

_____

_____

_____

Other Health Issues: _____

Mental Health Issues: _____

SUBSTANCE USE

- ☐ Abstinence
- ☐ Actively Using Substance(s)
- ☐ Currently Detoxing
- ☐ History of Use: _____
- ☐ None

Substance(s) of choice:_____

Pattern of use:_____

Primary Care provider: _____ Contact: _____

CCAC SUPPORT

Does the client require CCAC support in the community? (please circle) **Yes** **No**

If yes,

- ☐ **CCAC referral made**

Date of referral:_____

Service start date: _____

Coordinator:_____**Contact:**_____**ext.**_____

Reason for service:

- ☐ Occupational Therapist
- ☐ Personal Support Worker
- ☐ Physiotherapist
- ☐ RN, Specify Service:_____

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MEDICAL DEVICES

- ☐ Cast
- ☐ Catheter
- ☐ Drains (Specify Type): _____
- ☐ Dressings (Specify Type): _____
- ☐ Ostomy
- ☐ PICC line
- ☐ Port-O-Cath
- ☐ Other: _____

MOBILITY AIDS

- ☐ Cane
- ☐ Crutches
- ☐ Scooter
- ☐ Walker
- ☐ Wheelchair
- ☐ Other: _____

SAFETY RISKS

- ☐ Aggression Verbal/Physical
- ☐ Choking
- ☐ Cognitive Impairment
- ☐ Falls
- ☐ Seizures
- ☐ Self Harm
- ☐ Suicidal Ideations
- ☐ Other: _____
- ☐ Behaviours of Concern**:**_____

_____

I confirm I have attached:

- ☐ Current Med List
- ☐ Relevant consult notes (i.e. medical/surgical/Psych, Social Work, PT/OT, Wound care, etc.)
- ☐ Relevant Labs, Imaging and screening results (CXR, etc.)
- ☐ MRSA/VRE screening results (if available)
- ☐ Opiate Substitute Therapy (Methadone) Provider Information or □N/A
- ☐ Discharge Summary
- ☐ **List of follow up appointments (including name of person/service; location; date; tim**e)

Client is aware of this referral to the Infirmary Program	☐**Yes**	☐**No**
Client has participated in developing of the goals for a short term stay in the Infirmary.	☐**Yes**	☐**No**
Client has given verbal and/or written consent	☐**Yes**	☐**No**

_____ _____

Referee Signature Date

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