HOME AND COMMUNITY CARE SUPPORT SERVICES
Champlain

Referral Form for Home and Community Care Support Services

For Community Referrals - Fax Form to 613.745.6984 or 1.855.450.8569

Estimated Date of Discharge (EDD): (dd-mm-yyyy) (when applicable)		
Patient Details and Demographics		
Health Card #: VC: Province issuing Health Card: No Health Card #: ☐ No Version Code: ☐		
Surname:	Given Name(s):	
Home Address: No Known Address: ☐	City:	Province:
Postal Code: Tel: Alternate Tel:		
Address for Treatment: (Complete if different from Home Address):	City:	Province:
Postal Code: Tel : Alternate Tel :		
Date of Birth: (dd-mm-yyyy)	Gender: M ☐ F ☐	
Patient speaks/understands English: ☐ Yes ☐ No Interpreter required: ☐ Yes ☐ No Primary language: ☐ English ☐ French ☐ Other:		
Primary Alternate Contact Person: (Please Check All Applicable Boxes) Relationship: ☐ POA ☐ SDM ☐ Spouse ☐ Other:_____ Tel: Alternate Tel: No Alternate Tel:☐		
Secondary Alternate Contact Person: None provided:☐ (Please Check All Applicable Boxes) Relationship: ☐ POA ☐ SDM ☐ Spouse ☐ Other:_____ Tel: Alternate Tel: No Alternate Tel: ☐		

Health Information		
Community Health Care Provider (e.g. MD or NP) ☐ None	Surname:	Given Name(s):
Relevant Diagnosis for Referral:		
Reason for Referral:		
Allergies: ☐ NKA ☐ Yes --- if Yes, List Allergies:		
Infection Control ☐ None ☐ MRSA ☐ VRE ☐ CDIFF ☐ ESBL ☐ TB ☐ Other (specify):		
Attachment(s): ☐ None ☐ Medical Orders ☐ Primary Care ☐ InterRAI-PS ☐ Other(Specify):_____		

Referring Organization Information		
Referring Organization/Unit:	Organization Contact Number:	
Completed By:	Title:	Date:
Contact Tel:	Email address:	

Eligibility for Direct Services: Valid OHIP card; Assessment by a Health Care Professional.

If faxed, include Number of Pages (Including Cover):_____Pages

Confidential when completed. If you have received this form in error, please call 1.800.538.0520.

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Referral – Primary Care Addendum

Last Name, First name:		HCN:		VC:	

Detailed Health Information			
Primary Diagnosis			
Secondary Diagnosis			
PROGNOSIS □ Improve □ Remain Stable □ Deteriorate □ Maintenance	DIAGNOSIS DISCUSSED With Patient □ Yes □ No With Family □ Yes □ No	PROGNOSIS DISCUSSED With Patient □ Yes □ No With Family □ Yes □ No	
Relevant Medical History			
Surgical or other Procedures			
Medication	*Mandatory* (Use separate sheet if required) List all medications for Medication Reconciliation Purposes.		
Diet			
Allergies			

Services Requested	Notes, Orders, and Contraindications
☐ Care Coordination ☐ Nursing ☐ Personal Support/Care ☐ Physiotherapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Dietician ☐ Social Work ☐ ALS-HRS Program	Treatment will be taught and reduced, unless otherwise indicated.

Signature of Physician	
Signature:	Date:
Physician Name:	

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