

VANCOUVER HOME AND COMMUNITY CARE REFERRAL

Central Intake Tel: 604 -263 -7377 Fax: 604 -267- 3419

DATE: _____ PARIS # _____

PHN _____

The below-named has come under the care of Vancouver Coastal Health. As permitted by the **Freedom of Information and Protection of Privacy Act**, we are requesting that copies of his/her records be forwarded to the fax number on the left.

PATIENT DETAILS

Name: _____ Gender: M / F / Trans

Permanent Address: _____ (city): _____ Age: _____

Telephone: _____ DOB (dd/mm/yyyy): _____

Primary Contact (name): _____ Relationship: _____

Home Tel: _____ Cell: _____

PERSON SUBMITTING REFERRAL

Title _____

Name _____

Organization/office _____

Phone: _____

Fax _____

COMMUNICATION

Language: _____

Need for translator? Y N

Cognitively impaired? Y N

Client agreeable to

this referral Y N

PRESENT FUNCTION LEVEL

Independent

Requires assistance

Dependent

Is client housebound? Y N

Can client attend outpatient clinic? Y N

MEDICAL HISTORY AND DIAGNOSES (please list all current diagnoses & any recent surgeries)

CURRENT MEDICATIONS (attach list if available):

If the client is palliative (has less than a year), please call the Palliative Access Line @ 604-263-7255

ALLERGIES:

DISCIPLINE REQUESTED

- Nursing care** – please specify e.g. Wound care per Vancouver Health Wound Care Protocol, medication management/teaching, chronic disease management, etc
- Occupational Therapy** – e.g. ADL, safety assessment, wheelchair/scooter evaluation, swallowing assessment
- Physiotherapy Assessment** (for homebound clients only) – e.g. fall prevention, mobility aids, post surgery mobility and exercise progression
- Case Management** – e.g. Long Term Care assessment for home supports, facility placement, caregiver support, suspicion of abuse
- Nutrition Assessment** - (for homebound clients only)
- Speech Language Pathology** – Communication and complex swallowing (e.g. neuro conditions and/or requiring therapy)
- Others** -- please specify →

REASONS FOR REFERRAL / PHYSICIAN ORDER

CARE PROVIDERS INVOLVED:

Primary Care Physician: _____ Tel: _____ Fax: _____

Specialist(s): _____ Tel: _____ Fax: _____

Physician's Signature (Physician order is required for medication management)

Date

Phone #