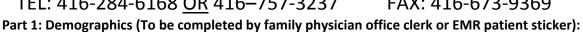
East GTA PSW Home Care Program Referral Form

TEL: 416-284-6168 OR 416-757-3237 FAX: 416-673-9369





Date of referral (D/M/Y) _____ Patient to be seen by **PSW only**. **NO** referral to **Dr. Punjani**. Name (Last) ______(First) _____
 Birth Date (MM/DD/YY)
 Health Card #

 Address
 City
 Postal Code

 Phone: (Home)
 (Work)
 (Cell)
Email _____ Marital Status: ____ How many children: _____ Next of Kin: Name_____ (phone) _____ Emergency Contact (Name) _____ (Phone) _____ Guardian/Parent (Name) ______ (Phone) _____ PART 2: Medical Diagnosis (To be completed by family physician and / OR their authorized representative): Reasons for Referral: Dx: Existing Health Concerns/Comorbidities: ☐ COPD ☐ Stroke / TIA ☐ Recent pneumonia < 1 YR ☐ CHF ☐ Cancer ☐ Dialysis: Peritoneal/Hemo \square HTN ☐ Chronic pain ☐ Vision Impaired ☐ CAD / MI / A.Fib ☐ Dementia/Alzheimer ☐ Hearing Impaired ☐ CKF/CRF ☐ Parkinson's Disease ☐ Speech impaired □ Diabetes ☐ Other mental health issues ☐ Mobility impaired ☐ Obesity Project OTHER ISSUES: CCAC Pre-Discharge Referral Completed: YES / NO DATE (MM/DD/YY): ____/____/ SIGNATURE: REFERRING MD: DATE OF REFERRAL (MM/DD/YY): ____/_ Part 3: Social services needed (To be completed by MCP Program staff): Assessment of non-medical reasons for referral (i.e. patient is experiencing challenges with): ☐ Recent repeated hospital admissions that may benefit from specialized out-patient follow-up ☐ Recent repeated emergency room visits that may benefit from specialized out-patient follow-up ☐ Frail elderly ☐ Transportation ☐ Ambulation/Balance ☐ Translation needed? ☐ Self-care/ADLs/Personal Hygiene ☐ Finances/Banking ☐ Swallowing solids/Liquids/Meds ☐ Communication/Comprehension ☐ Administering Meds ☐ Social Supports/Isolation ☐ Meal Preparation ☐ Emotion status (Depression, Anxiety) ☐ Housekeeping/Laundry ☐ Caregiver stress ☐ Shopping/Groceries

Other Issues: