105-840 Coxwell Avenue ,Toronto,ON M4C5T2
Tel. 416-469-6464
Fax. 416-469-6164

Integrated Home Based Primary Care
REFERRAL FORM

Date submitted: _____(DD/MM/YYYY)

CLIENT INFORMATION

First Name	Last Name	Marital Status
Address	Health Card No.	
Tel.	D.O.B.	Gender
Alternate Contact Name	Tel.	Relationship to Client
Languages ❑ English ❑ Other(s)		Planned Discharge Date
Client lives with: ❑ spouse ❑ companion ❑ children ❑ partner ❑ other (describe):		
Has Client been informed of referral? ❑ Yes ❑ No	First contact should be: ❑ Client ❑ Family ❑ Other	

CHECKLIST

Patient meets Eligibility Criteria?	**Yes**	**No**	**Comment**
Living in one of these post codes: M4C, M4E, M4H, M4J, M4K, M4L, M4M			
Patient is completely home-bound (it is impossible for patient to go out shopping or for medical appointments)			
Patient is not living in LTC or retirement home with primary care			
Patient is willing to be under our team physicians' care (patient will change his/her family doctor to our team doctor)			

CLINICAL INFORMATION

1. Current Medical Diagnoses and Dates of Onset (include medical, psychological issues)

2. Main Concerns

3. Past Medical and Surgical history:

4. Medication List (if more space required, please attach a separate list):

5. Are any hospital discharge summaries, laboratory tests, imaging, or specialist consultations available? If so, please attach to this form.

6. Is CCAC currently involved? If yes, with what services and how many hours? Who is the CCAC coordinator?

7. Are any additional services required (e.g., psychogeriatric assessment, etc.)?

8. Please check off all that apply:

□ High Falls risk
□ Depression/ Anxiety
□ ADL/IADL issues
□ Social Isolation

REFERRAL SOURCE

Name	Title and Organization	Tel / Pager

PLEASE INCLUDE PRIOR ASSESSMENTS AND CONSULTATION NOTES WITH REFERRAL IF AVAILABLE

Thank you for your referral!