South East Toronto Family Health Team

840 Coxwell Avenue
Tel. 416-463-6580 ext. 3054
Fax. 416-469-6164

Integrated Home Based Primary Care
REFERRAL FORM

Date submitted: _____(DD/MM/YYYY)

About our Program:

-Our team Home-visit program is providing the primary care to the total home-bound frail senior population.
-The program is OHIP covered. No extra charges.
-This program is not focusing on providing Mental Health services.
-The patient must meet Eligibility criteria to be able to get enrolled.

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		

ELIGIBILITY CRITERIA

	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)	
The patient is over 65 years old	

CLINICAL INFORMATION

1. Current Medical Diagnosis 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!