South East Toronto Family Health Team

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Home Visit Program

REFERRAL FORM

Date submitted:_____(DD/MM/YYYY)

About our Program:

-Our integrated team-based Home Visit Program provides 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, 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. Vaccination List:

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

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

7. Is Ontario Health @ Home currently involved? If yes, with what services and how many hours? Who is the coordinator?

8. Has a LTC application been made? When?

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

10. Please check off all that apply:

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

11. What are the client's goals of care?

REFERRAL SOURCE

Name	Title and Organization	Tel / Pager

PLEASE INCLUDE PRIOR ASSESSMENTS AND CONSULTATION NOTES WITH REFERRAL IF AVAILABLE

Thank you for your referral!