East GTA PSW Home Care Program Referral Form

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

Part 1: Demographics (To be completed by family physician office clerk or EMR patient sticker):

Patient to be seen by **PSW only**. **NO** referral to **Dr. Punjani.** Date of referral (D/M/Y) __________

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
☐ 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		

OTHER ISSUES: ____

CCAC Pre-Discharge Referral Completed: **YES / NO** DATE (MM/DD/YY): _____/______/______

REFERRING MD: _________________________ **SIGNATURE: ____________________________**
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
☐ Ambulation/Balance
☐ Self-care/ADLs/Personal Hygiene
☐ Swallowing solids/Liquids/Meds
☐ Administering Meds
☐ Meal Preparation
☐ Housekeeping/Laundry
☐ Shopping/Groceries

☐ Transportation
☐ Translation needed?
☐ Finances/Banking
☐ Communication/Comprehension
☐ Social Supports/Isolation
☐ Emotion status (Depression, Anxiety)
☐ Caregiver stress

Other Issues: ____