

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 & referral to geriatrician, Dr. Y. 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:

<input type="checkbox"/> COPD	<input type="checkbox"/> Stroke / TIA	<input type="checkbox"/> Recent pneumonia < 1 YR
<input type="checkbox"/> CHF	<input type="checkbox"/> Cancer	<input type="checkbox"/> Dialysis: Peritoneal/Hemo
<input type="checkbox"/> HTN	<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Vision Impaired
<input type="checkbox"/> CAD / MI / A.Fib	<input type="checkbox"/> Dementia/Alzheimer	<input type="checkbox"/> Hearing Impaired
<input type="checkbox"/> CKF/CRF	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Speech impaired
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other mental health issues	<input type="checkbox"/> Mobility impaired
<input type="checkbox"/> 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):

<input type="checkbox"/> Recent repeated hospital admissions that may benefit from specialized out-patient follow-up	
<input type="checkbox"/> Recent repeated emergency room visits that may benefit from specialized out-patient follow-up	
<input type="checkbox"/> Frail elderly	<input type="checkbox"/> Transportation
<input type="checkbox"/> Ambulation/Balance	<input type="checkbox"/> Translation needed?
<input type="checkbox"/> Self-care/ADLs/Personal Hygiene	<input type="checkbox"/> Finances/Banking
<input type="checkbox"/> Swallowing solids/Liquids/Meds	<input type="checkbox"/> Communication/Comprehension
<input type="checkbox"/> Administering Meds	<input type="checkbox"/> Social Supports/Isolation
<input type="checkbox"/> Meal Preparation	<input type="checkbox"/> Emotion status (Depression, Anxiety)
<input type="checkbox"/> Housekeeping/Laundry	<input type="checkbox"/> Caregiver stress
<input type="checkbox"/> Shopping/Groceries	

Other Issues: _____