ST JOSEPH'S HEALTH CENTRE TORONTO

AMBULATORY CARE CENTRE

ELDERLY COMMUNITY HEALTH SERVICES REFERRAL
30 The Queensway
Toronto, ON M6R 1B5
Tel: 416-530-6770 Fax: 416-530-6386

ADDRESSOGRAPH

Name: _____
Male ☐ Female ☐
MRN : _____
DOB: _____
Address: _____
_____
Telephone: _____
OHIP #: _____

Contact Person: _____ Relationship: _____ Phone #: _____

☐ Substitute Decision Maker: _____ ☐ Power of Attorney: _____

Language Spoken: _____ Interpreter Required? ☐ Yes ☐ No

Is this Client Currently Driving? ☐ Yes ☐ No

REASON FOR REFERRAL	ADDITIONAL INFORMATION
☐ Cognition/Dementia ☐ Falls ☐ Behavioural Difficulties ☐ Anxiety / Depression ☐ Polypharmacy / Med Review ☐ Other:_____	Additional Information Related To Referral: _____ _____ _____ Main Pharmacy: Name: _____Phone: #_____ Medications (Please list here or fax the list with referral): _____ _____ _____ _____ Past Medical History (Please fax summary / consult notes, if applicable) _____ _____ _____ _____ Is CCAC Involved? ☐ Yes ☐ No ☐ Not sure Other Agency Involvement? ☐ Yes ☐ No Other Agency Name:_____ Phone #:_____

REFERRAL INFORMATION

Name of Referring Physician (Print):_____

Signature of Referring Physician:_____ Date of Referral:_____(DD/MM/YYYY)

Phone #:_____ Fax #: _____ Billing #:_____

Please Attach: ☐ Recent Lab Results ☐ Recent Imaging Results
☐ Discharge Summary and Consult Notes within the last year

Number of Pages Faxed: _____ pages

For Office Use Only: