4353 County Rd 31, Box 278
Williamsburg, ON K0C 2H0
Tel 613-535-2215 Fax 613-535-1749
E-mail: info@dundascountyhospice.ca
www.dundascountyhospice.ca

CLIENT REFERRAL FORM

- ☐ Visiting Volunteer
- ☐ Palliative Day Program
- ☐ Equipment Lending (Please specify below in Comment section)
- ☐ Caregiver or Bereavement Support
- ☐ Complementary Therapies

Hospice use only

Client #: ______________________________

Referral Date: ______________________

Initial Contact Date: __________________

Assessment Date:____________________

Assessment Completed By: ____________

CIMS Input Date: ____________________

Part 1: Client Information

Client Name:	**Health Card No:**
D.O.B.: (Month/Day/Year)	**Male** ☐ **Female** ☐
Address:	
Phone:	**Cell/Alternate:**
Caregiver Name: **Phone:**	**Relationship:** **Cell/Alternate:**
Family Doctor:	**Phone:**
Nursing Agency:	**Homemaking Agency:**
Diagnosis: **PPS:**	
Past Medical History:	
Additional Comments:	

Part 2: Referral Information

Referral Source **Name:**_______________________________________ **Phone:** ___________________________

☐ CCAC ☐ Doctor ☐ Self ☐ Family ☐ Friend ☐ Nursing Agency

☐ Other ____

Confidential when completed. If you have received this form in error, please contact the originator.