Ontario
Toronto Central Local Health Integration Network

250 Dundas Street West, Suite 305, Toronto, ON M5T 2Z5 Tel: 416-506-9888 | 1-866-243-0061
Fax: 416-506-0374
www.healthcareathome.ca/torontocentral

REFERRAL FORM FOR HOME AND COMMUNITY CARE SERVICES

PLEASE FAX COMPLETED REFERRAL FORM TO TORONTO CENTRAL LHIN 416-506-0374
PLEASE PRINT CLEARLY

CLIENT INFORMATION

LAST NAME: ______________________ FIRST NAME: ______________________

HEALTH CARD # ______________________ VC______ DATE OF BIRTH: DD ______ MM ______ YYYY______

ADDRESS: ______________________ APT#______ ENTRY CODE: ______________

CITY: ______________________ PROVINCE: ______________ POSTAL CODE: ______________

PRIMARY TELEPHONE #: (______) ______________ ALTERNATE: (______) ______________

PREFERRED LANGUAGE: ______________________

PRIMARY CONTACT INFORMATION

LAST NAME: ______________________ FIRST NAME: ______________________

PRIMARY TELEPHONE #: (______) ______________ ALTERNATE: (______) ______________

PREFERRED LANGUAGE: ______________________

Reason for Toronto Central LHIN Service Referral:

Has the client fallen within the last 30 days?: Yes ☐ No ☐
Was the client in hospital within the last 30 days?: Yes ☐ No ☐
Is the Client/POA/SDM aware of this referral: Yes ☐ No ☐

REFERRAL SOURCE

NAME: ______________________ TELEPHONE: (___) ______________ FAX: (___) ______________

ADDRESS: ______________________ CITY: ______________ PROVINCE: ______ POSTAL CODE: ______________

PHYSICIAN / NURSE PRACTITIONER INFORMATION

REFERRING: ☐ PRIMARY CARE PRACTITIONER: ☐

NAME: ______________________ TELEPHONE: (___) ______________ FAX: (___) ______________

ADDRESS: ______________________ CITY: ______________ PROVINCE: ______ POSTAL CODE: ______________

OHIP BILLING CODE: ______________________ CPSO# ______________________

SIGNATURE: DATE:

CONFIDENTIAL WHEN COMPLETED. IF YOU HAVE THIS FORM IN ERROR PLEASE DO NOT COPY OR DISPOSE ***OF.*** *CONTACT 416-506-9888 AND WE WILL MAKE ARRANGEMENTS TO COLLECT IT.*

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LAST NAME: ______________________________ FIRST NAME: ______________________

HEALTH CARD # ______________________ VC_____

MEDICAL INFORMATION	
PRIMARY DIAGNOSIS	
SECONDARY DIAGNOSIS	
ALLERGIES	
RELEVANT MEDICAL HISTORY	
MEDICATION	Name: ______________Dosage: ____Frequency: _____Route: _____Duration: _____ Name: ______________Dosage: ____Frequency: _____Route: _____Duration: _____ Name: ______________Dosage: ____Frequency: _____Route: _____Duration: _____ Other: ____
MOBILITY	Ambulatory: ☐ Yes ☐ No Client uses: ☐ Wheelchair ☐ Walker ☐ Cane ☐ Scooter Other:____________________
SERVICES REQUESTED	PRESENTING ISSUES *(*important*- identify reason/need for each service checked)*
☐ Case Management ☐ Occupational Therapy ☐ Personal Care (bathing/dressing) ☐ Community Linking (i.e. homemaking) ☐ Physiotherapy ☐ Speech Language Pathology ☐ Social Work ☐ Dietitian/Nutrition ☐ LTCH Assessment ☐ Nursing: Wound Care ☐ Nursing: Other	*(for Nursing service, provide Treatment Orders and Start Date)*
☐ Telehomecare	☐ CHF ☐ COPD ☐ Chronic Bronchitis ☐ Emphysema
PHYSICIAN/NP SIGNATURE:	DATE:

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