

Complex Care Transition Program Referral Form

Date of Referral:		Does the Physician do Home Visits: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Patient information: Full Name: _____ PHN: _____ DOB: _____ Gender: _____ Address: _____ Phone Number: _____ Alternate Phone Number: _____		Referring Provider:		Provider Direct Number:	
		Family Physician			
		Clinic:		EWPCN Clinician Name:	
		Special Requirements: <input type="checkbox"/> Language Barrier <input type="checkbox"/> Needs Translator <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Other: _____			
		BP:	Weight:	Height:	BMI:
Is patient able to book own appointments: <input type="checkbox"/> Yes. <input type="checkbox"/> No. If no, who is the contact person? (first and last name, and phone number) _____					
Phone consult only: <input type="checkbox"/>					
<i>* This program is intervention and team based. If you prefer recommendations only, please specify. *</i>					
MANDATORY - Reason for Referral: (Please attach cognitive testing, pertinent labs results, clinical notes/ patient summary sheet, and a recent medication list not available on Netcare)					
Check all that apply:					
<input type="checkbox"/> ADL/ IADL Impairment <input type="checkbox"/> Functional Assessment <input type="checkbox"/> Change in Attention/LOC/Behavior <input type="checkbox"/> Homebound <input type="checkbox"/> Bowel/ Bladder Concerns <input type="checkbox"/> Medically Complex <input type="checkbox"/> Caregiver Stress/ Lack of Caregiver <input type="checkbox"/> Nutritional Concerns/ Unexplained Weight Changes <input type="checkbox"/> Cognitive Decline <input type="checkbox"/> Pain <input type="checkbox"/> Depressive Symptoms <input type="checkbox"/> Polypharmacy/Medication Concerns <input type="checkbox"/> Frequent Clinic / ED/ Acute Care Visits <input type="checkbox"/> Recent Falls/ Mobility Concerns <input type="checkbox"/> Sleep Concerns					
Other Involvement: <input type="checkbox"/> Homecare Involvement <input type="checkbox"/> Supportive Living <input type="checkbox"/> Recent Geriatric Assessment Completed Date: _____ Location: _____ <input type="checkbox"/> Recent Admission(s) _____ <input type="checkbox"/> Specialist involvement _____ <input type="checkbox"/> Recent/pending referrals			Special Requirements: <input type="checkbox"/> Needs Translator, Language: _____ <input type="checkbox"/> Severe Hearing or Visual Impairment <input type="checkbox"/> Other: _____ Are there any safety/ health concerns for a home visit (I.e. smoking, pets, aggressive behavior)? <input type="checkbox"/> Yes <input type="checkbox"/> No Please Specify: _____		
Other Concerns:					

Contact Phone Number 780 702 2617 | Fax completed form to 780-481-9149

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