



Casey House Services Referral Form

Please complete this electronic form, print out, sign, and

Fax to: 416-907-7186 **OR**

Mail to: Casey House, 119 Isabella Street, Toronto ON M4Y 1P2

***Please do not submit this referral form by email.**

Date of Request _____ Time _____

Name _____ Preferred Name _____

Date of Birth _____ OHIP # _____ VC _____

Address _____

Phone # _____ Email _____

Referred by _____

Relationship to Client GP/NP Self Family Member

Community Provider, specify _____

Specialist, specify _____

Other, specify _____

Referring Agent Phone #: _____ Email: _____

Reason for Referral _____

Brief Description of Health Issues/Concerns: _____

(Attach any recent/relevant consultations and/or investigations you think might be helpful (e.g. genotype, resistance testing, etc.) to clarify health or risk issues)

Identify any safety or risk issues for the client and/or worker

Current Medications (attach a list if available)

Drug Name	Dosage	Frequency	Rationale

Other Providers Engaged

Name	Agency	Phone #/Email

Service Requested

___ Day Health Program (ambulatory care program with interprofessional team - registered nurse\social work\recreation therapist\case managers\massage therapist\physiotherapist)
An intake worker will respond to this request within 2 business days.

___ Inpatient Program (Sub-acute hospitalization with 24-hours nursing and daily physician contact)
A nurse will respond to this request within 2 business days.

In order for Casey House to proceed with this referral, one of the selection below MUST be completed

If referring a client

I, _____, have received ___ written/___ verbal consent for Casey House to contact the client at the above phone #/email address.

Signature

If self-referring

I, _____, give permission for Casey House to contact me at the listed phone #/email address.

Signature