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 ______________________

Reason for Referral ____

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Brief Description of Health Issues/Concerns: ______________________

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(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

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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)

____ Inpatient Program (Sub-acute hospitalization with 24-hours nursing and daily physician contact)

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