Casey House Expanded Pandemic Services Referral Form

Referral Areas (please choose one):

- ◯ HIV+ and palliative
- ◯ HIV+ and has a stable medical condition
- ◯ HIV- and palliative*
- ◯ HIV- and has a stable medical condition*

* Please note that given the HIV focus of Casey House, HIV+ patients will be prioritized.

COVID-19 Swab Result:

- Negative, Date: _____
- Positive, Date: _____

Please fax completed referral forms to: **416-929-8849**
Questions? Please contact lhodge@caseyhouse.ca or ekucharski@caseyhouse.ca

Date of Request _____ Time _____

First Name _____Last Name_____

Preferred Name _____

Date of Birth _____ OHIP # _____ VC _____

Address _____

Phone # _____ Email _____

If applicable and/or available:

Emergency Contact Name: _____ Phone_____

Email _____

Power of Attorney Name: _____ Phone_____

Email _____

Advance Care Planning Completed? ◯ Yes ◯ No

Referred by: _____Signature:_____

Relationship to Client GP/NP

Community Provider, specify

___ Specialist, specify _____

___ Other, specify _____

Referring Agent Phone #: _____ Email: _____

Reason for Referral

_____

_____

_____

Brief Description of Health Issues/Concerns:

_____

_____

(Please 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 (please comment on mental health status and substance use status, including smoking)

_____

_____

_____

_____

_____

Medication Allergies: _____

Food Sensitivities/Allergies: _____

Other Sensitivities/Allergies: _____

Current Medications (attach a list if available)

Drug Name	Dosage	Frequency	Rationale

Other Providers Engaged

Name	Agency	Phone #/Email