

FHT HOME VISIT REFERRAL FORM

Fax to: 416-530-6160 Telephone: 416-530-6860



2) REFERRAL DEMOGRAPHICS:

Patient Name: _____ Patient Address: _____

Date of Birth: _____ Postal Code: _____

HCN (with version code): _____ Telephone Number: _____

Language(s) Spoken: _____ Major Intersection: _____

Email _____ Age _____

Interpreter required? Yes No

Alternate Contact Person: _____

Telephone Number: _____

Relationship to Client: _____

Pharmacy Name & Telephone Number: _____

LHIN Coordinator Name & Telephone Number (if applicable): _____

Prior Family MD Name: _____

Prior Family MD Telephone Number: _____

Date Last Seen by Family MD: _____

Does the current Family MD do home visits? Yes No

3) CLINICAL INFORMATION:

Provide a brief history and reason for referral:

Does the client have difficulty accessing a Family MD because of any of the following factors:

Physical

Cognitive

Mental health

Social

Other: _____

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Please complete the following chart to help us better understand your patient.

<i>Comorbidities</i>	<i>Yes/No</i>	<i>Details, if available</i>
CHF/CAD		
Chronic Renal Disease		
COPD/Asthma		
Prior CVA/TIA		
<i>ER Visits Last 1 Year</i>	<i>Yes/No</i>	<i>Details, if available</i>
None		
1-2		
Greater than 3		
<i>Medications</i>	<i>Yes/No</i>	<i>Details, if available</i>
Greater than 5 medications		
Greater than 12 daily dose events		
<i>Mobility</i>	<i>Yes/No</i>	<i>Details, if available</i>
Greater than 2 falls in the past 1 year		
Uses assisted device		
Bedbound		
Pressure injury in the last 1 year		

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<i>Mental Health</i>	<i>Yes/No</i>	<i>Details, if available</i>
MCI or Dementia		
History of physical aggression		
Wandering/Safety Concerns		
Other mental health concerns		
<i>Social Factors</i>	<i>Yes/No</i>	<i>Details, if available</i>
Socially isolated		
High functional care needs (greater than 4 hours/day)		
Concern for caregiver burnout		
Substance overuse concerns in the household		
Concern for elder abuse/neglect		

Please fax the completed referral to: 416-530-6160.

Please include any relevant past medical documents, including: medication list, immunization record, relevant consultant notes/diagnostic reports, POA and DNR documentation if available.

INTAKE NOTES (FOR OFFICE USE ONLY):