Emery-Keelesdale Nurse Practitioner-Led Clinic

Home Visiting Program Referral Form

2972 Islington Avenue, Suite 6, North York, ON M9L 2K6

Phone: 647-476-1351 Fax: 647-847-8467

□ **Toronto Central LHIN**

□ **Central LHIN**

□ **Central West LHIN**

Referral Date:

(*) MINIMUM REQUIRED INFORMATION

PATIENT INFORMATION*

Last Name: _____ First Name: _____ Middle Initial: _____

Health Card Number:_____ Expiry Date: _____

Birth Date (DD/MM/YY): _____ Sex: Male Female □

Home Phone Number: _____ Alternate No.: _____

Address: _____

Postal Code: _____ Nearest Intersection: _____

POWER OF ATTORNEY

Name of Power of Attorney:_____ Contact Number: _____

Relationship:_____ ☐ Documentation

REFERRAL SOURCE*

Name of Referral Source:_____ **Self:** ☐

Contact Phone: _____ Contact Fax: _____

Relationship:_____

REASON FOR HOME VISIT

☐ Frail Elderly ☐ Mental Health

☐ Other, please specify:

Medications (Write or please provide us with a copy of your current medication list)

Pharmacy

Name: _____ Telephone No.: _____

Address:_____ Fax number:_____

Current Doctor or Health Care Provider

Name: _____ Telephone No.: _____

Address:_____ Fax number:_____

Past Medical History

☐ Diabetes ☐ Heart Failure ☐ Surgeries, please specify:

☐ Hypertension ☐ COPD

☐ Cancer

☐ Other, please specify:

Allergies ☐ Yes ☐ No

If yes, please list:

REGULAR HOME HEALTH CARE PROVIDER

(*Please provide name, telephone number, and/or agency name*)

☐ Registered Nurse: _____

☐ Registered Practical Nurse: _____

☐ Personal Support Worker: _____

☐ Other: _____

LHIN (formerly CCAC)

Are you affiliated with the Local Health Integration Network? YES □ NO □

If yes, please check off the following services that you are receiving:

☐ Nursing

☐ Occupational Therapy

☐ Physiotherapy

☐ Wound Care Specialist

☐ Personal Support Worker

FOR INTERNAL USE:

Eligible: ☐ YES ☐ NO

HOME BLOODWORK SERVICES

If you are ineligible for for home bloodwork services, would you be able to pay **$30 - $45** for each home blood work visit?

☐ YES ☐ NO

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship to patient:_____

Address: _____

Home Phone Number: _____

Alternate Phone Number:

Notes/Comments:

PLEASE FAX BACK THIS FORM TO (647) 847-8467

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