## Emery-Keelesdale Nurse Practitioner-Led Clinic
## Referral Form: Home Visiting Program

2972 Islington Avenue, Suite 6, North York, ON M9L 2K6
Phone: 647-476-1351 Fax: 647-847-8467

**Date of Referral:**

**Please complete all sections of the referral form.**

### PATIENT INFORMATION

Last Name: ______________________________ First Name: ______________________________ Middle Initial: ________

Health Card Number: ______________________________________ Expiry Date: _______________________

Birthdate (DD/MM/YY): _____________________________ Sex: ☐ Male ☐ Female ☐ Other

Home Phone Number: ______________________________ Alternate Phone Number: ___________________________

Address: _____________________________________________________________________________________________

Postal Code: __________________________ Nearest Intersection: ___________________________________________

### POWER OF ATTORNEY / SDM

Name of Power of Attorney: _______________________________ Contact Number: _______________________________

Relationship: ____________________________________________ ☐ Documentation

### REFERRAL SOURCE

Name of Referral Source: _______________________________________ ☐ Self

Contact Phone Number: _____________________________ Contact Fax Number: _______________________________

Relationship: _______________________________________

### ELIGIBILITY CRITERIA

Unable to leave home for medical visits due to:

☐ Mental health (non-ambulatory and communicative)
☐ Dementia
☐ Bedbound
☐ Impaired mobility
☐ Terminal illness (palliative continuum)

### MEDICAL INFORMATION

#### Medications

(Please write or provide us with a copy of your current medication list.)

#### Pharmacy

Name: ____________________________________________ Telephone Number: ________________________________

Address: __________________________________________ Fax Number: ______________________________________

#### Current Doctor or Health Care Provider

Name: ____________________________________________ Telephone Number: ________________________________

Address: __________________________________________ Fax Number: ______________________________________

Are you willing to transfer care from your current doctor/NP to our home visiting program? ☐ Yes ☐ No

#### Past Medical History

☐ Diabetes
☐ Hypertension
☐ Cancer
☐ Other, please specify:
☐ Heart Failure
☐ COPD
☐ Surgeries, please specify:

## Allergies

Do you have any allergies? ☐ Yes ☐ No

If yes, please list:

## REGULAR CAREGIVER

Who lives at home with you?

Name: ____________________________________________ Contact Number: ___________________________________

Relationship: _______________________________________

Do you have pets? ☐ Yes ☐ No

## HOME AND COMMUNITY CARE SUPPORT SERVICES (formerly LHIN)

Are you affiliated with Home and Community Care Support Services? ☐ Yes ☐ No

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

☐ Nursing
☐ Occupational Therapy
☐ Physiotherapy
☐ Wound Care Specialist

☐ Personal Support Worker

Care Coordinator Name: ____________________________

## HOME BLOODWORK SERVICES

If you are ineligible for home bloodwork services, would you be able to pay **$30—$45** for each home bloodwork visit?
☐ Yes ☐ No

## EMERGENCY CONTACT INFORMATION

Name: ______________________________________________________________________________________________

Relationship to Patient: _________________________________________________________________________________

Address: ______________________________________________________________________________________________

Home Phone Number: ______________________________ Alternate Phone Number: ___________________________

**Notes/Comments:**

**PLEASE FAX THIS FORM BACK TO 647-847-8467**

## FOR INTERNAL USE ONLY

**Eligible:** ☐ Yes ☐ No