The Dorothy Ley Hospice
A COMMUNITY OF SUPPORT & CARE

Community Program Referral Form

For Individuals living in Etobicoke with a Life limiting Illness, their Families and Caregivers

REFERRAL FOR: *(Please provide full contact information)*

SURNAME: ____ **FIRST NAME:**__________________________________

Health card number: _________________________________ **Version code:** ________________________________

DOB: _______/_______/________**GENDER:** ☐**M** ☐**F** ☐**Transgendered** ☐**2 Spirited** ☐**Other** ______________
DD MM YY

Address: ____ _________________ ____________
(Street) (Suite or Room #) Entry Code

City: ____ **Postal Code:** __________________________

Phone: ( ) ___________ - _______________ **(Home) ( )** ___________ - _______________ **(Cell.)**

☐ **Lives Alone** ☐ **Young Children in the Home** ☐**Smoking in the Home** ☐ **Pet(s) in the Home (specify):** __________

Individual speaks English? ☐ **Y** ☐ **N Translator:** ____
(Name and Tel #)

Family/Informal Caregiver: (Check if this is the primary person to contact to schedule a home visit)

☐ **Name:** ____ **Tel:** ____

Relationship: ____

DIAGNOSIS INFORMATION:

Diagnosis: ____

Mets (if cancer): __________________________ **When diagnosed:** _______/_______/_______

Other significant medical issues : ____

PPS: ______________ **%** **Prognosis** ___________________________

Individual Aware of diagnosis ☐ **Y** ☐ **N Does not wish to know:** ☐ **Y** ☐ **N**

Family Aware of diagnosis ☐ **Y** ☐ **N Does not wish to know:** ☐ **Y** ☐ **N**

SERVICES REQUESTED / REASON FOR REFERRAL:

☐ Care Coordination Services
☐ Day Program
☐ Visiting Volunteer
☐ Caregiver Support
☐ Emotional/Spiritual Support
☐ Bereavement

Other Information we should know:

Referral Made By: *(Please provide full contact information)*

Name (Print): ____

Designation: Primary Care: ☐ NP ☐ GP **Acute Care:** ☐ ER ☐ Specialist ☐ Social Work ☐ Other _________

Agency name: ____ **Tel#:** _____________________________________

Email: ____ **Date (dd/mm/yr):** _______/_______/________

Forward to The Dorothy Ley Hospice
Fax: 416 626 7285 · Inquires: 416 626 0116 x 225