Taddle Creek
Family Health Team

PrimaryCare@Home Program Referral Form

Thank you for completing this form and faxing it to ***(416) 585-5815***

Referral is: ☐ Urgent ☐ Routine Date: _____

If urgent, please include explanation below:

REFERRAL SOURCE DETAILS:

REFERRED BY:

Name:

Organization:

Contact number: ext. Email address:

If a physician is involved in this referral, please provide the following:

Physician's name: Physician's billing number:

Physician's signature:

Supporting documents attached to referral: (if available)

☐ Recent Discharge Summary ☐ Cumulative Patient Profile
☐ Relevant Consultation Notes ☐ Other: _____

DEMOGRAPHICS OF PERSON (PATIENT) SEEKING CARE AT HOME:

Name: Phone:

DOB: OHIP#: VC:

Address: Unit:

City: Province: Postal Code:

PRIMARY CONTACT PERSON (IF DIFFERENT FROM ABOVE):

Name: Phone:

Relationship to patient: _____

Is this contact person the primary caregiver? ☐ Yes ☐ No

ELIGIBILITY FOR HOME-BASED PRIMARY CARE:

Please provide a brief description of the person's current issues prompting this referral:

Does the person have difficulty accessing a family physician? ☐ Yes ☐ No

Please describe issues in the following areas:

Physical:

Cognitive:

Psychiatric:

Social : (housing, financial issues)

Has the person been notified of the referral to the PrimaryCare@Home and do they consent to transferring their care to this team? ☐ Yes ☐ No

Does the person live within the Taddle Creek FHT PrimaryCare@Home catchment area?
(M5P, M4V, M5R, M5T, M5V, M5J, M5G, M6C, M6G, M6J, M5V) ☐ Yes ☐ No

Nearest major intersection:

SAFETY CONSIDERATIONS:

Does the client have any communicable diseases? ☐ Yes ☐ No

If yes, please specify:

Does the client have a history of verbal or physical aggression? ☐ Yes ☐ No

If yes, please specify:

Does the client's residence have a history of/or current bedbug/cockroach infestation?

If yes, please specify:

CURRENT HEALTH CONTEXT:

Has the client visited the hospital (Emergency/Inpatient) in the past 3 months? ☐ Yes ☐ No

If so, please indicate which hospital and reason for visit:

Does the person have a primary care provider (i.e. family physician)? ☐ Yes ☐ No

If yes, please provide the contact information of the primary care provider:

Name:

Phone: Fax:

Does the client receive CCAC services? ☐ Yes ☐ No

CCAC Coordinator:

Phone: Email:

Current services received:

CURRENT SOCIAL CONTEXT:

Does this person live alone? ☐ Yes ☐ No

Is there a power of attorney for personal care and/or finances? ☐ Yes ☐ No

If so, whom?

Languages spoken:

Do you perceive any communication barriers? ☐ Yes ☐ No

If so, describe:

Please provide any other information that may impact care below: