Centre Island Form

Home & Community Care Referral – Health Care Professional

Date: ________________________________

Referring Professional: ____________________________ Phone: ________________ Fax: ________________

Referral completed by ❒ MRP / clinician (above) or ❒ MOA / unit assistant ____________________________

Client Last Name: __________________________________First and Middle Name:________________________

Date of Birth (Day/Month/Year): _________________________________ PHN: _____________________

Client Permanent Address: ____Tel: __________________

Lives alone? ❒ Yes ❒ No

Alternate Contact: _________________________ Relationship: ________________ Tel: ___________________

Instructions:

1) **For *ALL* referrals**, **complete and fax this form to Central Intake at Fax: 1-877-754-2967**
2) **For *Urgent*** or ***At Risk*** clients, **also phone direct to Central Intake at Tel: 1-877-734-4141**

REASON for REFERRAL *(include problem list, current significant functional & medical issues which need addressing):*

1) Medical History *(attach client profile if available):*

2) ALLERGIES:

3) MEDICATIONS *(attach list if available):*

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Central Intake telephone number: **1-877-734-4141**