Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg
Caring for Health | *À l'écoute de notre santé*

HOME CARE REFERRAL FORM

Client Health Record #
Client Surname
Given Name
Date of Birth
Gender
MFRN
PHIN
Address (home visits only)

FAX TO: (204) 940-2227

☐ **CENTRAL INTAKE**

☐ **CENTRAL NURSING INTAKE**

☐ **AFTER HOURS SERVICE**

☐ **FACILITY/COMMUNITY AREA:**

ADMISSION DATE: D D M M M Y Y Y Y

DISCHARGE DATE: D D M M M Y Y Y Y

DATE SERVICES TO BEGIN: D D M M M Y Y Y Y

SERVICE (S) REQUESTED:

SERVICE ADDRESS (IF DIFFERENT FROM ABOVE):

PHONE (home): ( )
PHONE (alternate): ( )

CLIENT'S PRIMARY CONTACT NAME:

RELATIONSHIP:

PHONE (home): ( )

LANGUAGES: SPOKEN ☐ ENGLISH ☐ OTHER (SPECIFY):

UNDERSTOOD ☐ ENGLISH ☐ OTHER (SPECIFY):

MEDICAL DIAGNOSES:

ALLERGIES:

TREATMENT/MEDICAL ORDERS: ☐ SEE ATTACHED IF APPLICABLE

MEDICATION ORDERS: NAME/DOSE/ROUTE/FREQUENCY/DURATION ☐ SEE ATTACHED IF APPLICABLE

MEDICATIONS WILL BE IN HOME: ☐ YES ☐ NO IF NO, PROVIDE DETAILS:

LIST OTHER PROGRAMS/SERVICES INVOLVED: (attach list if more room needed)

PHONE: ( )

FAX: ( )

LIVING ARRANGEMENTS:
☐ Alone
☐ With Relatives
☐ With Others

FAMILY SUPPORT AVAILABLE:
☐ YES ☐ NO

SAFETY: (e.g. pets, smoking, etc.)

COMMUNICATION:
Vision Impairment . . . . . ☐ YES ☐ NO
Hearing Impairment . . . . . ☐ YES ☐ NO
Speech Impairment . . . . . ☐ YES ☐ NO

DAILY LIVING:
Is a client/family member able to:
Prepare Meals . . . . . ☐ YES ☐ NO
Do the Shopping . . . . . ☐ YES ☐ NO
Do the Housekeeping . . . . . ☐ YES ☐ NO
Manage Personal Care . . . . . ☐ YES ☐ NO

MOBILITY:
☐ Independent
☐ Independent with Equipment
☐ Needs Assist
☐ Wheelchair Independent
☐ Other:

CONTINENCE:
☐ Completely Continent
☐ Incontinent Urine
☐ Indwelling Catheter
☐ Incontinent Feces
☐ Other:

COGNITION AND BEHAVIORAL ISSUES:
Alert and Oriented . . . . . ☐ YES ☐ NO
Intact Memory . . . . . ☐ YES ☐ NO
Anxiety . . . . . ☐ YES ☐ NO
Depressed . . . . . ☐ YES ☐ NO
☐ Other:

COMMENTS:

PHYSICIAN'S NAME AND ADDRESS:

PHONE: ( )

FAX: ( )

NAME OF REFERRAL SOURCE (printed):

PHONE: ( )

FAX: ( )

SIGNATURE AND DESIGNATION:

DATE: D D M M M Y Y Y Y