

## Seniors at Risk in Hamilton (SaRiH) Referral Form

Date of Referral: \_\_\_\_\_

### Referral Source Information

Name of Agency/Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### Client Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_(yyyy) \_\_\_\_\_(mm) \_\_\_\_\_(dd)

Preferred Pronouns: \_\_\_\_\_ Gender Identification: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Language Interpreter Needed? Yes  No

OHIP #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Is client aware of the referral? Yes  No

Who should we contact regarding the referral?  Client  Family  POA  Care Partner  Other

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Living arrangement: \_\_\_\_\_ Pets: \_\_\_\_\_ Infestation at home: \_\_\_\_\_

Presenting Issue(s): \_\_\_\_\_

Recommended Intervention: \_\_\_\_\_

Relevant Diagnosis(es): \_\_\_\_\_

Physical Functioning (mobility aid, chronic conditions): \_\_\_\_\_

Cognitive Functioning: \_\_\_\_\_

Social Functioning: \_\_\_\_\_

List of services presently involved with client (Days/Week): \_\_\_\_\_

Additional Information: \_\_\_\_\_