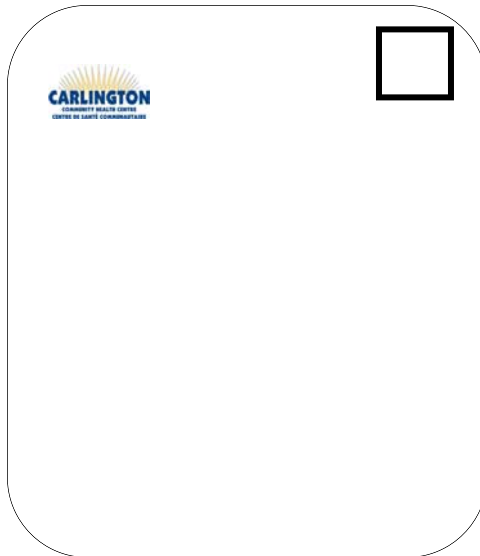
Primary Care Outreach to Seniors

Referral Form Date:

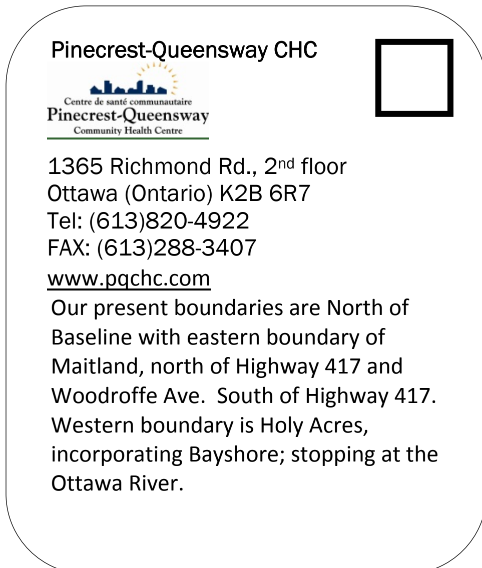
Client Information:

NAME:	D.O.B.
ADDRESS:	HEALTH CARD #:
	CLIENT CONTACT #:
LANGUAGE SPOKEN:	NEED FOR CULTURAL INTERPRETATION: *CircleYES or NO*
CLIENTS AGREES TO REFERRAL: *CircleYES or NO*	

Please choose a local Community Health Centre (CHC):



www.centretownchc.org



Pinecrest-Queensway CHC

1365 Richmond Rd., 2nd floor
Ottawa (Ontario) K2B 6R7
Tel: (613)820-4922
FAX: (613)288-3407
www.pqchc.com

Our present boundaries are North of Baseline with eastern boundary of Maitland, north of Highway 417 and Woodroffe Ave. South of Highway 417. Western boundary is Holy Acres, incorporating Bayshore; stopping at the Ottawa River.

For generalinquiries, call: Cathie Racicot, Program Coordinator
(613) 737-5115 ext. 2418

Referral Source

☐ Public Health	☐ CCAC	☐ Home Support	☐ Health Care Provider
☐ Hospital	☐ Housing	☐ Family	☐ Other ________________

Referral Source Name ____

Referral Source contact numbers __________________________ __________________________

Does client meet one or more of the following criteria?

☐ Frail ☐ ER visit last 3 months
☐ Lives alone/isolated ☐ Recent falls/fear of falls
☐ Difficulty keeping appointments or no shows ☐ Confusion/Memory problems
☐ Fear/concern re abuse ☐ At risk of eviction
☐ Accompaniment ☐ Home safety assessment
☐ Case Management ☐ Cognitive assessment
☐ Hospital/ER discharge ☐ Caregiver stress
☐ Polypharmacy ☐ Chronic illness monitoring
☐ In need of family physician

Living Arrangement

☐ Live alone
☐ Spouse/LP
☐ Other, who?

Does client have a Health Practitioner? ☐ Yes ☐ No

Practitioner Name ____

Health Practitioner contact numbers __________________________ __________________________

Is Health Practitioner aware of this referral? ☐ Yes ☐ No

Client medical conditions/problems:

1. ______________________________ 2. ______________________________
3. ______________________________ 4. ______________________________
5. ______________________________ 6. ______________________________
7. ______________________________ 8. ______________________________

Are any other services involved?

☐ CCAC	☐ Home Support	☐ R.G. P.E.O
☐ DayHospital	☐ Seniors Centre	☐ Other ________________

NOTE: Please attach an extra form if needed