RVH RENFREW VICTORIA HOSPITAL

Community Geriatric Coordinator/Social Work Referral Form

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Client Demographics:

Name	Age	DOB	Sex ☐ F ☐ M ☐ Other

Address	Phone Number

Health Card no.	Version Code	Marital Status: ☐Single ☐ Married ☐ Widow ☐ Separated ☐ Divorced ☐ C-L Partner

Client is aware, agreeable and consents to referral and sharing of health information? ☐ Yes If no, unable to proceed with referral

Family Physician

Name Aware of referral? ☐ Yes ☐ No	☐ Check if referral is urgent; What issues make this referral urgent?

Referral Source

Name ☐ as above	Relationship to Client	Phone

Reasons for Referral (check all that apply)

☐ Adjusting to new diagnosis	☐ Self Neglect	☐ Financial Insecurity
☐ Advocacy & Referral/Navigation	☐ Family & Social Supports/Caregiver Stress	☐ Future Planning
☐ Advanced Care Planning	☐ Mood/Grief	☐ Power of Attorney
☐ Suspected/Known Abuse	☐ Other:________________	

Relevant Medical History

Goals of Referral

Other Services Involved (e.g. Champlain LHIN)

Alternate Contact Person

Name	Relationship	
Phone: Home	Work	Cell

Who should be contacted for appointment? ☐ Client ☐ Alternate Contact

Printed Name	Signature	Referral Date