KW4 Community Ward Referral Form

In-Home Health & Outreach Team

Date of Referral (mm/dd/yyyy):

Reason for Referral for In-Home Assessment

Referral Criteria Checklist: **(This is a mandatory field)**

NOTE: We do not accept referrals for patient who require solely one criterion, there must be **2 or more** of the checkboxes selected below

- ☐ Has 4 or more chronic medical conditions. Please list conditions:
- ☐ Social Determinants of Health are affecting above conditions
- ☐ Barriers to accessing appropriate resources

Has patient consented to an interdisciplinary team approach, including:

- ☐ **Medication Reconciliation** Please include medication list and past medical history
- ☐ **Mental Health and Community Resource Assessment** Please include any past history and known supports
- ☐ **Mobility Assessments** Please include past imaging
- ☐ **Primary Care Consultation** Please include past medical history, recent bloodwork

Signature of Patient (if available):

Signature of Person Making Referral:

Referral Information

Referral Agency/ Practice:

Contact Person: **Telephone #:**

Patient Primary Care Provider: **Telephone #:** **Same as above:** ☐

Patient Information

Name: **Date of Birth** (MM/DD/YYYY):

Phone: **Health Card #:** *include version code: **Is Heath Card # Valid:** ☐ **Yes** ☐ **No**

Address: *include postal code:

Alternative Contact Name: **Phone:** **Relationship:**

Interpretation Required: ☐ **Yes** ☐ **No** **Language Preferred:**

Additional Information and Goals

Referral Source Goal(s):

Patient Goal(s):

Known Support? Please list:

Please ATTACH or EXPLAIN: Medical History, labs, imaging, other documents that may be pertinent information (if available)

Office Only

Consent for referral received by: Date:

Updated: April 2024