KW4 Community Ward Referral

In-Home Health & Outreach Team

Date of Referral (mm/dd/yyyy): ____ / ____ / ____

Referral Information

Name:	**Date of Birth (mm/dd/yyy):**
Telephone Number:	**Health Card #:**
Address:	

Contact Number to Arrange Visit:

☐ As a above, or:

Alternative Contact: (name, telephone, relationship)

Referred By:

☐ **Family Physician** ☐ **Community Agency** ☐ **Self** ☐ **Other:**

Name of Physician/Agency:

Contact Person: **Telephone:** **Fax:**

Reason for Referral for In-Home Assessment

Referral Criteria:

- 4 or more chronic/high cost conditions, including a focus on mental health and addictions, palliative patients and frail elderly
- Social determinants: low income, unemployment, housing, social isolation, vulnerable population
- Experience barriers to traditional care

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

Additional Information and Goals

Referral Source Goal	
Client Goal	
Known Supports	
Are there communication barriers? i.e. doesn't have a phone	
Other Information	

(Attach supplementary medical information/documents if pertinent/available)

Signature of Referred Person (if available)

Signature of Person Making Referral