KW4 COMMUNITY WARD

In-Home Health & Outreach Team

Phone: 519-578-4562 | Fax: 519-578-3366 | Website: KW4communityward.ca

Date of Referral

_____

(MM/DD/YYYY)

Reason for Referral or In-Home Assessment

Referral Criteria Checklist (Mandatory):

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

- ❒ Has 4 or more chronic medical conditions
- ❒ Social Determinants of Health are affecting chronic medical conditions
- ❒ Barriers to accessing appropriate resources

Please list medical conditions:

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: **Phone:**

Patient Primary Care Provider: **Phone:** ❒ **Same as above**

Patient Information:

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

Phone: **Health Card #:** *Include version code **Is Health 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 Use Only

Consent for referral received by:	Date: