Haldimand-Norfolk Community Senior Support Services Inc.
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HOSPICE
Referral Form

Client Demographics:				**Referral Date:**			
Name:				Telephone:			
Address:		City:		Postal Code:			
Date of Birth:		Age:		Marital Status:		Ont. Health Card #:	
Cultural considerations:				Allergies:			
Is client capable for making personal care decisions?				Yes		No	
If no, who is the substitute decision maker or Power of Attorney for personal care?							
Name:				Telephone:			
Relationship to client:							
Primary Caregiver Demographics							
Name of Primary Caregiver:							
Relationship to client:							
Telephone:	Home:			Work:			
Address:		City		Postal Code:			
Client Medical Information:							
Client diagnosis:							
Current communicable diseases or past communicable diseases the client would have been exposed to:							
Client prognosis:		DNR order:		Yes		No	
Complications:							
Primary M.D.:		Telephone:					
Verbal client or substitute decision maker consent for volunteer involvement is necessary for referral.							
Consent Obtained:	Yes		No		Additional Comments:		
Referring person (please print):		Referring Agency:					
Signature of Referring Person:		Date of Referral:					
Telephone Number:							