Confidential

The Heart of Hastings Hospice
Client Referral Form

Phone: (613) 473-1880
Fax: (613) 473-4070
Email: info@heartofhastingshospice.ca

Services Requested: ☐ All			
☐ In-home volunteer visiting	☐ Caregiver Support Sessions	☐ Residential Hospice	☐ Grief Support

Referral Information:		
Referred By:	Date:	Consent from Client/POA? ☐ Yes ☐ No
Phone Number:	Email:	

Client Information:			
Client Name:		Date of Birth:	
Address:		Phone #:	
Health Card:	Version:	Current Supports: ☐ Care Coordinator ☐ Nursing ☐ PSW ☐ Alzheimer Society ☐ Other Supports: _____	
Physician:	Phone #:		
Care Coordinator:	Phone #:		
Diagnosis:	Prognosis:	PPS:	DNR: ☐ Yes ☐ No
Functional Limitations : ☐ Vision ☐ Hearing ☐ Cognitive ☐ Ambulation ☐ Behaviours		Risks: ☐ Falling ☐ Choking	
Infectious Diseases:	Allergies:		
Notes:	Height (allows us to identify equipment needs): Weight (allows us to identify equipment needs):		

Caregiver Information:		
Caregiver Name:	Relationship to Client:	Is Caregiver Power of Attorney? ☐ Yes ☐ No
Address: ☐ same as above	Phone #:	

Heart of Hastings Hospice USE ONLY:		
Assessed by:	Date:	Client #

FOR ANY QUESTIONS OR CONCERNS PLEASE CONTACT US AT (613) 473-1880 OR INFO@HEARTOFHASTINGSHOSPICE.CA