Home For Life

Referral Form - Fax to: 705-445-1516

Admin: 705-444-0040 ext. 149

Client Information **Is this a Health Link Patient?** ◯ **Yes** ◯ **No**

Name: Date of Birth (yyyy-mm-dd):

Address:

Phone # or Alternate Method of Contact:

Client identifies as: ◯ Male ◯ Female ◯ Trans Other:

Income Source: ◯ CPP/OAS ◯ OW/ODSP Other:

Name of Alternate Contact (relative/emergency):

Phone # of Alternate Contact:

Consent Information

The client or their substitute decision maker agrees with this referral and the collection and sharing this referral information with the Central Referral Service and Home for Life: ◯ Yes ◯ No

Referral Source/Form Completed by: Name:

Organization: Phone:

Email: Date (yyyy-mm-dd):

Referred for the following services below or describe:

- ☐ Friendly visiting (unable to leave home)
- ☐ Friendly visiting (able to attend outings)
- ☐ Grocery shopping (unable to leave home)
- ☐ Grocery shopping (with client)
- ☐ Laundry (pick up, drop off)
- ☐ Dog walking
- ☐ Yard work (occasional)
- ☐ Basic computer support (occasional)

Describe any pertinent medical information that is helpful for providing volunteer services (mobility, sight or hearing limitations etc.) and also other key influencers such as pets or smoking:

Primary goal(s) and outcomes established for this client with this referral: