Carewest
INNOVATIVE HEALTH CARE

Day Hospital Direct Referral

Missing or incomplete information will delay processing. Please attach discharge summary and any relevant information or reports.

☐ **Day Hospital Program** ☐ **Living with Dementia Program**

Date: ______________________ YYYY/MM/DD

Last Name: ________________________ First Name: ________________________

Gender: M ☐ F ☐ DOB: ______________________ PHN: ____________________

Address: ____

City: _______________________ Post Code: ______________________

Home Phone: ______________________ Alt Phone: _________________________

Is client able to book his/her own appointment?	***Y*** ☐	***N*** ☐
Is client able to participate in full day program (approx. 5 hrs.)?	***Y*** ☐	***N*** ☐
Has client had cognitive screening (please attach)?	***Y*** ☐	***N*** ☐

Contact Person: ___________________________ Relationship: ______________________
Phone: ____

Referring Source: ____
Phone:_____________________ Fax: _______________________

Name of Family Physician (*if different from referring source):* _______________________
Phone: _____________________ Fax: _______________________

Referring Program Area:

☐ RCTP	☐ Neuro Rehab	☐ CAR
☐ Geriatric Mental Health R &R	☐ GARP	☐ PCN
☐ Seniors Health	☐ MSK	☐ Family Physician
☐ Acute Care – Unit	☐ Home Care	

Access Calgary Number: ____

Home Care Coordinator: ____

Anticipated Discharge Date: _______________________YYYY/MM/DD

Diagnosis: ____
____
____

Rehab Potential requiring two or more therapy disciplines:

☐ Social Work ☐ Registered Nurse ☐ Psychologist

☐ Speech Language Pathologist ☐ Occupational Therapist ☐ Physiotherapist

☐ Recreational Therapist

Please explain the specific rehabilitation goals and reasons for referral: ____________
____
____
____

Does client require medical monitoring? ***Y*** ☐ ***N*** ☐
If yes, please explain:
____
____
____

Special Requirements:

☐ Requires O2

☐ Hearing, visual impairment etc

☐ Activity Limitations

☐ Unable to speak/read/comprehend English (specify language spoken)
Name of interpreter: ______________________ Phone:______________________

Please include the following information if available:

☐ Physiotherapy, Occupational Therapy, Speech Language Therapy and Recreation Therapy assessments

☐ Any relevant medical information and test results ☐ Discharge Summary *(if applicable*)

☐ Any cognitive tests completed and their results ☐ A medication list

☐ Geriatric Assessment *(if applicable)*

Please fax completed form and additional information to Carewest Day Hospital Fax: (403) 258-7681

For questions or concerns, please call (403) 640-6480.

<u>Exclusion Criteria:</u>

- Client exhibits behaviors that are disruptive, abusive and/or put themselves or others at risk.
- Client is unwilling to participate in rehabilitation activities.
- Client is under 65
- Client requires more than one person standby assistance with transfers