Carewest
INNOVATIVE HEALTH CARE

Day Hospital

Client Information			
Last Name	First Name		Middle Name
Street Address	City	Province	Postal Code
Home Phone	Work Phone	Cell Phone	
Date of Birth	Male ☐ Female ☐	PHN#	

Alternate Contact Information			
Name of Contact:		Relationship:	
Use alternate Contact ☐ Yes ☐ No	Home Phone	Work Phone	Cell Phone
Living Situation (Lives with)		Other	
Interpreter Required ☐ Yes ☐ No		Language Spoken	

Reason for Referral

Most Responsible Diagnosis (include any pertinent medical history)

Medical or Activity Restriction (i.e. Cardiac concerns)

Allergies

Community Supports			
Home Care		Day Program	
Case Manager		Phone	Other
Family Physician Name	Phone	Fax	Date notified of referral

☐ Geriatrician assessment requested

Rehabilitation

Has client accessed rehabilitation services in the past 3 months? ☐ Yes ☐ No
If **Yes** where _____
Has the client had a recent decline in their mobility and/or function? ☐ Yes ☐ No
Does client demonstrate consistent ability and motivation to participate in active rehab? ☐ Yes ☐ No

Please fax completed form to 403-258-7681

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Falls

Has the client had two or more slips, trips or falls in the past year? ☐ Yes ☐ No
Details _____

Does the client have any trouble with walking or balance? ☐ Yes ☐ No
Details _____

Attach Copies of the following (if available)

Do Not send information that is available on NetCare

☐ Discharge Summaries ☐ Interdisciplinary Assessment or Progress Notes
☐ Other _____

Referrals made to other Physician/Services/Program (i.e. Consult to Physiatrist)

Physician Name	Service/Program	Date (YYYY-Mon-DD)	Time (hh:mm)	Reason

Cognition

Cognitive Impairment ☐ Yes ☐ No
If **Yes**, describe _____
_____

Cognitive Screen/Score Date (YYYY-Mon-DD)
MOCA _____/30 _____
Or
MMSE_____/30 _____

Is there a diagnosis of Dementia? ☐ Yes ☐ No

Education Level _____

Behavior

Behaviors/mood that may hinder rehabilitation? Describe (i.e. impulsive, substance abuse, depression, etc.)

Communication

Communication Impairment ☐ Yes ☐ No
If **Yes**, describe

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Current Status (check all that apply)	
Precautions	☐ Yes ☐ No ☐ MRSA ☐ VRE ☐ CDIFF ☐ Other:_____
Bariatric	Weight _____ kg BMI_____
Visual Impairment	☐ Right ☐ Partial ☐ Full ☐ Left ☐ Partial ☐ Full Details _____
Hearing Impairment	☐ Right ☐ Partial ☐ Full ☐ Left ☐ Partial ☐ Full Details _____

Basic Activities of Daily Living	**Independent**	**Standby Assist**	**One Person Assist**	**Two Person Assist**
Self Care				
Transfer				
Ambulation				
Mobility Aids				

Weight Bearing Restrictions ☐ Yes ☐ No If **Yes**, describe

Comments

Referral Form Completed by	
Print Name	Signature
Contact Number	Date (YYYY-Mon-DD)