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 ☐ Other ☐	PHN#	

Alternate Contact Information			
Name of Contact:		Relationship:	
Use alternate Contact ☐ Yes ☐ No	Home Phone	Work Phone	Cell Phone
Language Spoken: ☐ English ☐ Other: _____SPECIFY_____			

Reason for Referral

Most Responsible Diagnosis (include any pertinent medical history)

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

Allergies

Community Supports			
Home Care Case Manager:		Phone	Fax
Family Physician Name	Phone	Fax	Date notified of referral
Access Calgary in place? ☐ Yes ☐ No		Access Calgary Registration #:	

☐ 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 discharge 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 _____

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)	
Bariatric	Weight _____ kg BMI_____
Visual Impairment	☐ Yes ☐ No
Hearing Impairment	☐ Yes ☐ No

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)
Organization	