Carewest
INNOVATIVE HEALTH CARE

Day Hospital

Client Information			
Last Name	First Name		Middle Name
Street Address	City	Province	Postal Code
Home Phone	Cell Phone	Marital Status	
Date of Birth	Gender	PHN#	
Language Spoken: ☐ English ☐ Other: _____SPECIFY_____		Email Address	

Please use Alternate Contact to book appointment? ☐ **Yes** ☐ **No**

Name of Contact:		Relationship:
Home Phone	Cell Phone	Work Phone

Reason for Referral

Rehabilitation	
Is the client struggling with increased isolation?	☐ Yes ☐ No
Has the client experienced an increase in pain over the last six months?	☐ Yes ☐ No
Has the client had a recent decline in their mobility and/or function?	☐ Yes ☐ No
Has the client had any falls in the last six months?	☐ Yes ☐ No
Has the client had a decline in mood in the last six months?	☐ Yes ☐ No

Most Responsible Diagnosis **(include any pertinent medical history)**

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

Allergies

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Barriers to rehabilitation		
Describe (i.e. impulsive, substance abuse, depression, etc.)		
		Comments
Transfer Independently	☐ Yes ☐ No	
Ambulation Independently	☐ Yes ☐ No	
Mobility Aids	☐ Yes ☐ No	
Visual Impairment	☐ Yes ☐ No	
Hearing Impairment	☐ Yes ☐ No	

Community Supports			
Home Care Case Manager:	Phone:	Fax:	
Family Physician Name:	Phone:	Fax:	Notified ☐ Yes ☐ No
Access Calgary Registration #:			

Physician/Services/Program involved in client care)		
Name	**Service/Program**	**Reason**

Print Name	Signature
Contact Phone Number: **Contact Fax Number:**	Date (YYYY-Mon-DD)
Organization	

Please fax fully completed form to 403-258-7681