Carewest
INNOVATIVE HEALTH CARE

Day Hospital - Referral

Please fax completed form to (403) 258-7681
Referral must be made by health care provider.

Patient Information			
Last Name:	First Name:		Middle Name:
Street Address:	City:	Province:	Postal Code:
Home Phone:	Cell Phone:		
Date of Birth (YYYY/mon/DD):		PHN:	Marital Status:

Alternate Contact Information		
Use alternate contact: Y/N	Home Phone:	Cell Phone:
Living Situation (Lives With):		Work Phone:
Interpreter Required: Y/N	Language(s) Spoken:	

Goals for Referral

Eligibility		
Has the client experienced an increase in pain over the past six months?	Yes	No
Has the client had a recent decline in mobility and/or function?	Yes	No
Has the client had a decline in mood in the last six months?	Yes	No
Is the client struggling with increased isolation?	Yes	No
Has the client had any falls in the last 12 months?	Yes	No
If yes, how many? _____		
Has the client accessed rehabilitation services in the past 3 months?	Yes	No
If yes, where? _____		

Most Responsible Diagnosis (include any pertinent medical history)

Medical or Activity Restriction (i.e.cardiac concerns, weight bearing, etc.)

Services Requested: (check all that apply)					
Nursing	☐	Social Work	☐	Geriatrician	☐
Physiotherapy	☐	Recreation Therapy	☐	Geriatric Psychiatry	☐
Occupational Therapy	☐			Pharmacy	☐

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Current Status			**Comments**
Transfer Independently	Yes	No	
Ambulation Independently	Yes	No	
Mobility Aids	Yes	No	
Visual Impairment	Yes	No	
Hearing Impairment	Yes	No	
Can client function independently in a group setting and follow instructions related to a treatment plan?			
	Yes	No	
Cognitive Impairment	Yes	No	
If yes, has personal directive or guardianship been enacted? Yes No			
If enacted, please provide contact information for above.			
Name:			Phone Number:

Barriers to Rehabilitation - Describe (i.e. impulsive, mood concerns, pain, cognition, substance use)

Allergies

Community Supports	
Family Physician/Nurse Practitioner Name:	
Phone:	Fax:
Home Care Case Manager Name:	
Phone:	Fax:
Access Calgary Registration Number:	

Physicians/Services/Program Involved in Client Care		
Name	Service/Program	Reason

Other Comments

Referral Source	
Name:	Organization:
Phone:	Fax:
Date:	
Signature:	