Day Hospital - Referral

Please fax completed form to (403) 258-7681
Referral must be made by a 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): ULI: Marital Status:
Has personal directive (PD) or guardianship been enacted: Y / N
If yes, please provide contact information:
Name: _____ Phone Number: _____
Language(s) Spoken: Interpreter Required: Y / N
Home Care Services: Y / N Access Calgary Registration #:

Alternate Contact Information

Name: Living Situation (Lives With):
Home Phone: Cell Phone:
Use alternate contact: Y / N

Most Responsible Diagnosis (include any pertinent medical history)

Goals for Referral (not a problem list)

Services Requested:	***Goals for specific disciplines:***
☐ Physiotherapy	
☐ Occupational Therapy	
☐ Recreation Therapy	
☐ Nursing	
☐ Social Work	
☐ Geriatrician	
☐ Geriatric Psychiatry	

Eligibility

Is the client *independent* with: Comments (equipment, assistance, etc):

Toiletting Yes No _____
Transfers Yes No _____
Ambulation Yes No _____
Mobility Aids:_____

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Eligibility (continued)		
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? _____		
Has the client previously attended the Day Hospital Program?	Yes	No
If yes, when? _____		

Current Status			Comments
Allergies	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	

Medical or Activity Restriction (i.e.cardiac concerns, weight bearing, etc.) or Barriers to Rehabilitation (impulsive, mood, pain, cognition, substance use, etc.)

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

Other Comments

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