

Please fax completed form to (403) 258-7681

Referral must be made by a health care provider.

PATIENT INFORMATION		
Last Name:	First Name:	Middle:
Street Address:		
City:	Province:	Postal Code:
Home Phone	Cell Phone:	
Date of Birth:	ULI:	Marital Status:
Language(s) Spoken:	Interpreter Required?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home Care Services: <input type="checkbox"/> Yes <input type="checkbox"/> No	Access Calgary Registration #:	
Has personal directive (PD) or guardianship been enacted? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please provide contact information:		
Name:		Phone Number:
ALTERNATE CONTACT INFORMATION		
Name:	Living Situation (Lives with):	
Phone:	Use Alternate Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
MOST RESPONSIBLE DIAGNOSIS (include any pertinent medical history)		
CLIENT GOALS		
Services Requested	Primary Goals for Specific Disciplines (please describe)	
	<i>*General program structure/socialization will not be accepted as a discipline-specific goal.</i>	
<input type="checkbox"/> Physiotherapy		
<input type="checkbox"/> Occupational Therapy		
<input type="checkbox"/> Recreation Therapy		
<input type="checkbox"/> Nursing		
<input type="checkbox"/> Social Work		
<input type="checkbox"/> Geriatrician		
<input type="checkbox"/> Geriatric Psychiatry		
ELIGIBILITY		
Is the client <i>independent</i> with:	Comments: (equipment, assistance, etc.)	
Toileting: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Transfers: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Ambulation: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Mobility Aids:		

ELIGIBILITY (continued)			
Has the client experienced an increase in pain over the past 6 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Has the client had a recent decline in mobility and/or function?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Has the client had a decline in mood in the last six months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is the client struggling with increased isolation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Has the client had any falls in the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<i>If yes, how many?</i>			
Has the client accessed rehabilitation services in the past 3 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<i>If yes, where?</i>			
Has the client previously attended the Day Hospital Program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<i>If yes, when?</i>			
CURRENT STATUS			Comments:
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Visual Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hearing Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cognitive Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Can the client function independently in a group setting and follow instructions related to a treatment plan?			
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
MEDICAL OR ACTIVITY RESTRICTION (e.g. cardiac concerns, weight bearing, etc.) or BARRIERS TO REHABILITATION (impulsive, mood, pain, cognition, substance use, etc.)			
PHYSICIANS/SERVICES/PROGRAMS INVOLVED IN CLIENT CARE			
Name	Service/Program	Reason	
OTHER COMMENTS			
REFERRAL SOURCE			
Name:		Designation:	
Organization:		Date:	
Phone:		Fax:	
Signature:			

Appendix

Day Hospital Services

The table below lists a compilation of services frequently offered by the multi-disciplinary team at the Carewest Day Hospital. This is not an exhaustive list; the services offered in the program can change at any time due to staffing and competency. If needed, use this list to help complete the referral form.

Discipline	Services Offered/Referral Goals (not an exhaustive list)
Nursing	<ul style="list-style-type: none">– Monitor orthostatic hypotension and support client in implementing OH management or other BP issues– Monitor weight; review nutritional status– Review non-pharmacological management of constipation– Review non-pharmacological management of urinary incontinence– Monitor client's use of medication
Physiotherapy	<ul style="list-style-type: none">– Address deconditioned status– Improve balance– Improve strength– Improve range of motion– Assess for appropriate gait aid
Occupational Therapy	<ul style="list-style-type: none">– Equipment needs to improve functional transfers and mobility– Assess lower leg edema– Skin and wound monitoring
Social Work	<ul style="list-style-type: none">– Supportive counselling (ex. Illness adjustment, grief, anxiety, depression, family dynamics)– Education on Advance Care Planning– Financial resources– Caregiver's support– Community resources
Recreation Therapy	<ul style="list-style-type: none">– Engagement in independent leisure– Facilitate connection to community programs– Community resources