REFERRAL FORM
SENIOR SUPPORT SERVICE - CPHC

Senior Support Services

HOW DID YOU HEAR ABOUT US?

☐ CPHC Website ☐ CPHC Presentations ☐ Social Media ☐ Physician / Care Provider

☐ Friend/Family ☐ Other:

CLIENT INFORMATION

mm/dd/yyyy

NAME: **REFERRAL DATE:**

ADDRESS:

Street#/Apt# Street Name City Province Postal Code

AGE: **D.O.B:** **GENDER:** ☐ Male ☐ Female **OHIP #:**

HOME PHONE #: **CELL #:**

ALTERNATE CONTACT (*If applicable*): **RELATIONSHIP:**

PHONE #:

REFERRAL SOURCE INFORMATION

NAME: **PHONE:**

REFERRAL SOURCE: ☐ Family: ☐ Physician/NP/Physician Assist. ☐ Ontario Health ☐ SMILE

☐ Geriatric Mental Health Comm. Team ☐ Self ☐ Regional Care Coordinator

☐ ODSP ID# ☐ Ontario Works ☐ Other:

SERVICES REQUESTED

☐ ADULT DAY PROGRAM ☐ TRANSPORTATION ☐ MEALS ON WHEELS (HOT OR FROZEN)

☐ FOOT CARE ☐ DINERS CLUB ☐ HOME HELP / HOME MAINTENANCE

☐ IN-HOME RESPITE ☐ LIFELINE ☐ EXERCISE & FALL PREVENTION

☐ STROKE SURVIVOR AND CAREGIVER SUPPORT GROUP ☐ APHASIA SUPPORT GROUP

ADDITIONAL COMMENTS

Please return the completed referral form by FAX: (613)342-8992.

Questions? Please call our staff at (613)342-3693 or 1-800-465-7646