dundas county hospice
4353 County Rd 31, Box 278
Williamsburg, ON K0C 2H0
Tel 613-535-2215 Fax 613-535-1749
E-mail: info@dundascountyhospice.ca
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CLIENT REFERRAL FORM

☐ Visiting Volunteer

☐ Palliative Day Program

☐ Equipment Lending (Please specify below in Comment section)

☐ Caregiver or Bereavement Support

☐ Complementary Therapies

Hospice use only

Client #: _____

Referral Date: _____

Initial Contact Date: _____

Assessment Date:_____

Assessment Completed By: _____

CIMS Input Date: _____

Part 1: Client Information

Client Name:	**Health Card No:**
D.O.B.: (Month/Day/Year)	**Male** ☐ **Female** ☐
Address:	
Phone:	**Cell/Alternate:**
Caregiver Name:	**Relationship:**
Phone:	**Cell/Alternate:**
Family Doctor:	**Phone:**
Nursing Agency:	**Homemaking Agency:**
Diagnosis: **PPS:**	
Past Medical History:	
Additional Comments:	

Part 2: Referral Information

Referral Source **Name:**_____ **Phone:** _____

☐ CCAC ☐ Doctor ☐ Self ☐ Family ☐ Friend ☐ Nursing Agency

☐ Other _____

Confidential when completed. If you have received this form in error, please contact the originator.