The Dorothy Ley Hospice
A COMMUNITY OF SUPPORT & CARE

Community Program Referral Form

For Individuals living in Etobicoke with a Life-limiting Illness, their Families and Caregivers

REFERRAL FOR: *(Please provide full contact information)*

SURNAME: ____ **FIRST NAME:**_____________________________________

Health card number: ___________________________________ **Version code:** ___________________________________

DOB: _______/_______/________ **GENDER:** ☐M ☐F ☐Transgendered ☐2 Spirited ☐Other ______________
DD MM YY

Address: ____ ________________ ____________
(Street) (Suite or Room #) Entry Code

City: ____ **Postal Code:** ____________________________

Phone: ( ) ___________ - _______________ (Home) ( ) ___________ - _______________ (Cell.)

☐ **Lives Alone** ☐ **Young Children in the Home** ☐**Smoking in the Home** ☐ **Pet(s) in the Home (specify):** ___________

Individual speaks English? ☐ **Y** ☐ **N** **Translator:** ____
(Name and Tel #)

Family/Informal Caregiver: (Check if this is the primary person to contact to schedule a home visit)

☐ **Name:** ____ **Tel:** ____

Relationship: ____

DIAGNOSIS INFORMATION:

Diagnosis: ____

Mets (if cancer): ____________________________ **When diagnosed:** _______/_______/_______

Other significant medical issues : ____

PPS: ______________ **%** **Prognosis** ____________________________

Individual Aware of diagnosis ☐ **Y** ☐ **N** **Does not wish to know:** ☐ **Y** ☐ **N**

Family Aware of diagnosis ☐ **Y** ☐ **N** **Does not wish to know:** ☐ **Y** ☐ **N**

SERVICES REQUESTED / REASON FOR REFERRAL:

☐ Care Coordination Services	☐ Day Program	Other Information we should know:
☐ Visiting Volunteer	☐ Caregiver Support	
☐ Emotional/Spiritual Support	☐ Bereavement	

Referral Made By: *(Please provide full contact information)*

Name (Print): ____

Designation: Primary Care: ☐ NP ☐ GP **Acute Care:** ☐ ER ☐ Specialist ☐ Social Work ☐ Other _________

Agency name: ____ **Tel#:** ______________________________________

Email: ____ **Date (dd/mm/yr):** _______/_______/________

Forward to The Dorothy Ley Hospice
Fax: 416-626-7285 · Inquires: 416-626-0116 x 225