



Referral Intake Form

Referral Information

Referred by: _____ Date: _____

Client Information

Name: _____ Date of Birth: _____ (DD/MM/YY)

Phone: _____ Email Address: _____

Address: _____

Street

Apt #

City

Postal Code

Current Location: Home Other (please provide details): _____

Family and/or Caregiver Information:

Name	Relationship	Contact

Medical Information

Diagnosis: _____

Is client aware of diagnosis? Yes No

Is family aware of diagnosis? Yes No

Anticipated prognosis: _____

Is client aware of prognosis? Yes No

Is family aware of prognosis? Yes No

Health Care Provider Information:

Provider/Agency	Contact Information	Comments

Is the client aware that the referral to Hospice is being made? Yes No

Other Information:

Hospice Orillia is a program of the North Simcoe Muskoka Hospice Palliative Care Network

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