Hospice Orillia - Referral Form
Please fax completed form to 705-325-7328.

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 Info

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

Medical Information (*skip if referral is for grief & bereavement support*)

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

About the Loss (*skip if referral is for life-limiting illness support/caregiver support*)

Name of individual who died: _____

Relationship to the individual: _____

Have the individual received support for this loss before: ☐ Yes ☐ No

Other Information (use the space below to provide any additional information you feel we should know)