



SERVICE REQUESTS / REFERRALS

Community Service Request: 1-833-515-1234 | **Fax:** 1-866-839-7299

Hospital Request: Please see Hospital Care Coordinator

Demographics / Client Details	Patient Name: _____ Health Card Number: _____
	Address: _____ Street Suite City/Town Province Postal Code
Referral Information	Date of Birth: ____ DD ____ MM ____ YYYY Phone Number: _____ Alternate Number: _____
	First Language: _____ Preferred Language for Service: ☐ English ☐ French
	Primary Contact Name: _____ Relationship: ☐ POA ☐ SDM ☐ Other _____
	Contact Phone Number: _____ Alternate Contact Phone Number: _____
	Is patient aware of request: ☐ Yes ☐ No <i>If No, Reason not aware:</i> _____
	Has SDM provided consent for referral to Ontario Health atHome If yes, please explain: ☐ Yes ☐ No
	Name of Person requesting service: _____ Relationship to Patient: _____
	Contact Phone Number: _____ Contact Fax Number: _____
	Planned Hospital Discharge Date (if applicable): ____ DD ____ MM ____ YYYY
	Diagnosis (Primary): _____
Diagnosis(es) (Secondary): <i>Include also related surgical procedures / past medical history</i>	
Reason for Referral:	
Ontario Health atHome Services Include: Nursing in clinic (in-home by exception) Social Work, Speech Therapy, Nutrition, Physiotherapy, Occupational Therapy, Personal Support and assessment for Long Term Care eligibility.	
Medical Responsibility will be provided by (please print): _____	
Hospital Physicians must ensure medical responsibility transferred to primary care physician / practitioner should treatment require medical monitoring post Hospital discharge.	
Source of Information – Person completing this form (please print) _____	
Signature: _____ Date: _____ Time: _____	