# Community Support Services Referral

http://www.northeastcss.ca/

**If faxed, include number of pages (including cover): _________ pages**

## Client Details and Demographics

Health Card #: ______________________ Version: ________ Province Issuing Health Card:

☐ No Health Card # ☐ No Version Code First Nation Status # (if applicable): ______________

Surname: ______________________ Given Name(s): ______________________

Home Address: ______________________ Municipality/City: ____________ Province: ________

Postal Code: ____________ ☐ No Known Address

Telephone: ext. Alternate Telephone: ext. ☐ No Alternate Telephone

Date of Birth: ____________ Gender: M F Other

What is your mother tongue? English French Other (Specify): ____________ Interpreter Required? Yes No

If neither French nor English, in which of Canada's official languages are you most comfortable? English French

Comments: ______________________________________________

Primary Alternate Contact Person: ______________________ Relationship: ______________

Check if applicable: ☐ Power Of Attorney (☐ Documentation viewed) ☐ Substitute Decision Maker ☐ Other: ________

Telephone: ext. Alternate Telephone: ext. ☐ No Alternate Telephone

Conduct call-back with: (please check one): Client or Alternate Contact or Client wishes to be contacted by e-mail

Best time to call: ______________________ Email address: ______________

## Requested Community Service

Requested Community Service (please check off all that apply):

- ☐ Acquired Brain Injury Services
- ☐ Adult Day Programs
- ☐ Alzheimer/Dementia Services
- ☐ Assisted Living/Supportive Housing
- ☐ Care for the Caregiver
- ☐ Deaf and Impaired Hearing
- ☐ Exercise and Falls Prevention Programs
- ☐ Foot Care
- ☐ Friendly Visiting – Social/Safety
- ☐ Group/Congregate Dining
- ☐ Home Help and Homemaking
- ☐ Home Maintenance
- ☐ Hospice Palliative Care
- ☐ Independence Training and Rehabilitation
- ☐ Meals on Wheels
- ☐ Personal Emergency Response Services
- ☐ Personal Support and Independence Training
- ☐ Post Vision Loss Services
- ☐ Professional Services (Nursing, OT, PT) offered by First Nation Providers
- ☐ Respite
- ☐ Rides and Transportation
- ☐ Stroke Services
- ☐ Telephone Reassurance and Security Checks

## Referrer Information

Referring Facility/Unit: ______________________ Facility Contact Number: ext.

Completed By: ______________________ Title: ______________ Date: ________

Contact #: ext. Fax #: ______________

Follow-up Required: Yes No ☐ Consent to refer obtained from client

This form contains personal health information that is subject to the provisions of the *Personal Health Information Protection Act.* The information is collected for the purpose of referring patients to local community support agencies which offer services that may benefit them. Community support agencies will only use the information to assess patient eligibility and arrange services as required.