Community Referral for Carefirst Transitional Care Service

300 Silver Star Blvd., Scarborough, ON M1V 0G2 Tel: 416-502-2323
Please fax to 416–502–2382

Date received _____

Personal Information:

Client's Name (Last, First):_____ Sex: ☐ M ☐ F OHIP (Version)/ Health Insurance: _____

Client's Home Address: _____ Postal Code_____

Phone: _____ Age: _____ Date of Birth (D/M/Y): _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced lives ☐ alone ☐ spouse ☐ family ☐ other _____

Primary Language: ☐ English ☐ Cantonese ☐ Mandarin ☐ Tamil ☐ Tagalog ☐ other_____ Understand English: ☐ Yes ☐ No

1st Emergency Contact Name (Last, First):_____ Relationship: _____

Address: _____ Phone: _____

2nd Emergency Contact Name (Last, First):_____ Relationship: _____

Address: _____ Phone: _____

Diagnosis:

Current Medical Issue: _____

_____

Surgical Procedure/Date: _____

_____

Mental Status/Date (Orientation, Psych.): _____ Current Substance use: ☐ Yes ☐ No

_____

Allergies: _____

Name of Medication	Dose	Frequency	Route	Vital Signs/Other Relevant Information
				BP Sitting Standing Pulse Temp
				SaO_2 O_2 Therapy L/min Resp
				Pain (0-10, where) HT WT
				Diet
				TB Skin Test mm Induration
				Date of Chest X-ray Result
				Date of Flu Shot Date of Pneumovax
				MRSA VRE C. Difficile Other
				Labs

Functional Status	Independent	W/Assist	Unable	Assistance Devices (Specify)/Other Information
Ambulation				☐ walker ☐ wheelchair ☐ cane
Transfers				☐ transfer board ☐ hoyer lift
Feeding				☐ tube feeding ☐ bolus/continuous
Toileting				☐ raised TS ☐ versaframe
Personal Hygiene				☐ TTB ☐ bathseat
Vision	☐ Normal	☐ Impaired		☐ glasses
Hearing	☐ Normal	☐ Impaired		☐ hearing aids ☐Lt ☐Rt
Speech	☐ Normal	☐ Impaired		
Bowel	☐ Continence	☐ Incontinence		
Bladder	☐ Continence	☐ Incontinence		
History (Hx) of Falls	☐ Yes	☐ No		
Hx of Wandering	☐ Yes	☐ No		
Behavioral issues	☐ Yes	☐ No		
CCAC/services	☐ Yes	☐ No		Coordinator:

Family Physician:_____ Address:_____ Phone: _____Fax:_____

Referrer: ☐ Self ☐ Health Care Provider ☐ Internal Services ☐ others_____

Reason for Referral:_____

Name of Referrer: _____Signature:_____ Phone: (Work) _____ (Cell) _____

Address: _____ (Fax) _____ Date: _____

Please contact us for the fee schedules and feel free to make copies or call us for e-copy