

# Community Support Services Referral



North East Ontario Home & Community Care  
United in our Commitment to Care  
Soins communautaires et à domicile du Nord-Est de l'Ontario  
Unis dans notre engagement



<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):

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

## 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.

North East Ontario

**North East Connect Referral Contact Information**

**Service Referral Information:**

[Wahnapiatae First Nation - Norman Recollet Health Centre - Community Wellness Worker Program](#)

259 Taighwenini Trail Rd, Capreol, ON, P0M 1H0

**Referral Contact:**

Beatrice Debassige, Health Assistant, [beatrice.debassige@wahnapiataefn.com](mailto:beatrice.debassige@wahnapiataefn.com)

Phone: 705-858-0610, Fax: 705-858-5570

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