

# 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):

☐ 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.

North East Ontario

**North East Connect Referral Contact Information**

**Service Referral Information:**

[Ininew Friendship Centre - Cochrane - Life Long Care Program - Congregate Dining](#)

190 3rd Ave, Cochrane, ON, P0L 1C0

**Referral Contact:**

Marlene Archibald, Care Support Worker, [llc2@ininewfc.ca](mailto:llc2@ininewfc.ca)

Phone: 705-272-4497 ext 224, Fax: 705-272-3597

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