

Community Support Services Referral

<http://www.northeastcss.ca/>



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



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

[March of Dimes Canada - North East Region - Kirkland Lake and Temiskaming area](#)

213 Whitewood Ave W, New Liskeard, ON, P0J 1P0

Referral Contact:

Deanna Chisholm-Tullio, Regional Director -Community Support Services, dchisholmtullio@marchofdimes.ca

Phone: 705-671-3188 ext 3121, Fax: 705-671-6240
