

Community Support Services Referral



North East Ontario Home & Community Care
United in our Commitment to Care
Soins communautaire 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:

[Metis Nation of Ontario \(MNO\) - Haileybury - Community Support Services - Friendly Visiting](#)

439 Ferguson Ave, Haileybury, ON, P0J 1K0

Referral Contact:

Emma de Wit, Aging at Home Coordinator, emmaw@metisnation.org

Phone: 1-800-263-4889 ext 7
