SPECIALIZED SERVICES:
Retirement Home Support Program and Crisis Intervention Referral

Please fax or email referral to:
519-845-1364 or specializedservices@lambtonelderlyoutreach.org

REGISTRANT'S INFORMATION **DATE: _____**

* *Mandatory*	**Health Card #:**	**V.C.:**	**Expiry:**
Last Name:			
First Name:	**Middle Initial:**		
Birth Date:			
Gender – ☐**Female** ☐**Male** ☐**Intersex** ☐**Trans** ☐**Do Not Know** ☐**Prefer Not to Answer**			
Street Address - P.O. Box # (if required)			
City/Town, Prov.:			
Postal Code:			
Email:	**Internet Access? Yes ☐ No ☐**		
Home Phone #:	**Cell Phone #:**	**Yes, you may text ☐**	
Contact Person or Next of Kin:	**Phone #:**		

What details can be left in a message? (please check or mark boxes below)

Caller's Name:☐ Agency Name:☐ Phone Number:☐ Reason for Call:☐

Follow Up Required:☐ Appointment Information:☐

(after the second failed attempt to contact you, your alternate will be phoned/emailed)

Barrier to Communication

Limited/No English ☐ Cognitive ☐ Hearing ☐ Sight ☐
Other:

_____

_____

_____

If not comfortable speaking in English, is an interpreter needed?
Yes ☐ No ☐ Do Not Know ☐

Created: March 2022

Clinical Notes - O.T./P.T. Assessment ☐ Other Clinical Notes ☐

Reason for Referral

GP Contact Name: _____

OPGT Involved Yes ☐ No ☐

POA/SDM Yes ☐ No ☐

Elder Abuse:

☐ **Physical** ☐ **Financial**
☐ **Neglect** ☐ **Self-Neglect**
☐ **Psychological**

☐ Abuse ☐ Financial ☐ Advocacy

☐ Housing ☐ Socialization

☐ Crisis/Hard to Serve ☐ Forms

Other -

Retirement Home: Yes ☐ No ☐

Crisis Intervention? Yes ☐ No ☐ Case Management? Yes ☐ No ☐
Is this referral from an Emergency Department Yes ☐ No ☐

If yes, please specify the hospital: _____

Client Consent to Referral: ☐ Yes* (*Client POA/SDM must provide consent for referral)

Referral Source Name: _____

Agency Name: _____

Office Mailing Address: _____

Phone: _____

Fax: _____