Casey House Expanded Pandemic Services Referral Form

Please fax completed referral forms to: 416-929-8849
Questions? Please contact referral@caseyhouse.ca or dial 416-962-4040 ext. 8000.

Date of Request (yyyy-mm-dd):

Client / Contact Information	
First Name:	Last Name:
Preferred Name:	
Pronouns: ◉ she/her ○ he/him ○ them/they ○ Not Listed:	
Date of Birth (yyyy-mm-dd):	
OHIP Number:	Version Code:
Address:	
Phone Number:	Email:

Referring Agent Information (if applicable)	
First Name:	Last Name:
Relationship to client: (please put in your organization name/relationship if applicable)	
○ GP/NP: ○ Community Provider: ○ Specialist: ◉ Not Listed:	○ Family Member/ Partner/ POA: ○ Social Worker/ Case Manager:
Organization:	
Address:	
Phone Number:	Email:

Program Area	
○ Inpatient	○ Day Health Program

For more information on program areas please see: https://www.caseyhouse.com/accessing-care/refer-a-client/

Reason for Referral (Please select all that apply)	
HIV STATUS: ◯ Positive ◯ Negative	
COVID SWAB RESULTS: ◯ Positive ◯ Negative DATE OF RESULTS (yyyy-mm-dd):	
A. Palliative Needs (Please elaborate on comments section)	
☐ Palliative ☐ Medical Assistance in Dying (MAiD) ☐ Not Listed:	Additional Comments/ Information:
B. Medical Needs (Please elaborate on comments section)	
☐ IV Therapy ☐ Chemo Support ☐ Acute Infection ☐ Complex Wound Care ☐ Post-Op Support ☐ Not Listed:	Additional Comments/ Information:
C. Mental Health Needs (Please elaborate on comments section)	
☐ Mental Health Symptoms ☐ Medication Support ☐ Substance Use Support ☐ Not Listed:	Additional Comments/ Information:
D. Respite (Please elaborate on comments section)	
☐ Increase Weight/Strength ☐ Caregiver Respite ☐ Not Listed:	Additional Comments/ Information:

Goals of Admission (Please state the intended outcomes of admission)

Current Medications Please attach a current medication list from your pharmacy or health provider, or please provide **Pharmacy** or **Health Provider** Contact Information below:			
Pharmacy Name, Location	Contact Number	Health Provider Name, Location	Contact Number