Please fax completed referral to **647-689-6225**

Clinical Referral

Please fill out the fields below to the best of your knowledge and click submit at the bottom once completed.

Referral For

First Name:

Last Name:

Preferred Name:

Date of Birth:

Health Card Number:

Version Code:

Gender:

Primary Language:

Home Address:

City:

Postal Code:

Current Location:

If currently in hospital, which hospital?

Anticipated Hospital Discharge Date:

Client has consented to Hospice Referral:

Urgency of Response:

Is Marigold the client's first choice for hospice residence?

Please list the hospice residences in order of preference:

Contact Information

Primary Referral Contact

First Name:

Last Name:

Relationship:

Home Phone:

Mobile Phone:

Substitute Decision Maker

First Name:

Last Name:

Relationship:

Home Phone:

Mobile Phone:

Diagnosis:

Metastatic spread, if malignant:

Other relevant diagnosis / symptoms:

Past Medical History:

If cancer diagnosis, ongoing treatment? :

Individual Aware of Diagnosis:

Date of Diagnosis:

Prognosis:

PPS:

DNR:

Medical Allergies:

Infection Control:

- ☐ None
- ☐ C-DIFF+ - *Contact Droplet, Contact*
- ☐ Chicken Pox – *Airborne*
- ☐ ESBL+ - *Contact*
- ☐ HIV+ - *Contact*
- ☐ Hepatitis+
- ☐ Lice – *Contact*
- ☐ MRSA+ - *Contact*
- ☐ Other – *Airborne*
- ☐ Other – *Contact*
- ☐ Other – *Droplet*
- ☐ Other – *Specify*
- ☐ Other – *Standard*
- ☐ Respiratory – *Droplet*
- ☐ Scabies – *Contact*
- ☐ Shingles – *Airborne*
- ☐ TB – *Airborne*
- ☐ VRE+ - *Contact*

Current Community Services:

Current Care Needs:

- ☐ Central Line(s)
- ☐ Chest Tube(s)
- ☐ Dialysis
- ☐ Enternal Feeds
- ☐ Feeding Tube
- ☐ Hydration IV
- ☐ Hydration SC
- ☐ Infusion Pump(s)
- ☐ Ostomy Care
- ☐ Oxygen
- ☐ P.I.C.C. Line(s)
- ☐ Paracentesis
- ☐ PortaCath
- ☐ Pressure Ulcer(s)
- ☐ Therapeutic Surface
- ☐ Thoracentesis
- ☐ Tracheostomy
- ☐ Transfusion
- ☐ Wound Care
- ☐ Other

Care Needs, Detailed:

PHARMACY INFORMATION

First Name:

Last Name:

Phone:

Additional Information:

Referring Individual Information

First Name:

Last Name:

Phone:

Fax:

Referring Physician/MRP

First Name:

Last Name:

Phone:

Fax:

Email:

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