Date of Referral:
_____/_____/_____

KW[4] Community Ward Referral (In-Home Complex Needs Team)

Telephone: 519-883-5542 Fax: 519-571-3967

Referral Information

Name:	**Date of Birth:**
Telephone Number:	**Health Card Number:**
Address:	

Contact Number to Arrange Visit:

☐ as above, or

Alternative Contact: (name, telephone, relationship)

_____

_____

Referred By:

☐ **Family Physician** ☐ **Community Agency** ☐ **Self** ☐ **Other** _____

Name of Physician or Agency: _____

Contact Person: **Telephone:** **Fax:**

Reason for Referral for In-Home Assessment

Referral Criteria:

- 4 or more chronic/high cost conditions, including a focus on mental health and addictions, palliative patients and frail elderly
- Social determinants: low income, unemployment, housing, social isolation, vulnerable population

☐ **Mobility Assessment**	**Please include past imaging**
☐ **Medication Reconciliation**	**Please include medication list and past medical history**
☐ **Mental Health and Addictions**	**Please include any past history and known supports**
☐ **Primary Care at Home**	**Please include past medical history, recent bloodwork**

Additional Information and Goals

Referral Source Goal: _____

Client Goal: _____

Known Supports: _____

Other Information: _____

_____

(Attach supplementary medical information/ documents if pertinent/available)

Referred Person consents to being contacted by a team member: ☐ yes ☐ no

Referred Person consents to a message being left for them from the Community Ward: ☐ yes ☐ no

_____ _____

Signature of Referred Person (if available) **Signature of Person Making Referral**

Updated August 2015