Community Home Support
- Lanark County -
Services for Seniors and Adults with Physical Disabilities

Fax to appropriate office:
Perth: 613-267-3497
Smiths Falls: 613-283-8568

CLIENT REFERRAL FORM

Client Information		
Surname:	First:	Middle:
Address:		Tel #:
Alternate Contact Person (if applicable):		Speak with: ❍ Client ❍ Alternate Contact
Alternate phone #:	Relation to Client:	
Date of Birth:	Health Card #:	
Physician:	Physician #:	
Is client/caregiver aware of referral?	❍ Yes	❍ No

Please attach most recent assessment

Additional Information	
Health Information/Diagnosis:	*Is Palliative care status confirmed? YES/NO *Is there a Home DNR-C? YES/NO
Services currently in place:	
Reason for referral:	

Services Required			
❍ Meals on Wheels	❍ Transportation	❍ Diners Club	❍Footcare (Clinic Only)
❍ In-Home Respite	❍ Volunteer Hospice Visiting Service		❍ Home Help

Referral Information			
❍ Physician	❍ FHT	❍ CHC	Reason for admission to hospital:
❍ ED	❍ Inpatient		
❍ Other:			

Additional Information:

Referral Source Name: _____ Tel #: _____
Date: