VON SMILE Program Referral Form

SMILE Fax *(for referrals & assessments only)*: **1-833-255-5672**

Client Information

First Name:	**Last Name:**	**HN:**
Address:	**Apt:**	**City:**
Province:	**Postal Code:**	**Phone Number:**
Age ***(senior must be 75 years or above)***:	**DOB:** (DD/MM/YY)	**Sex:** ☐ Female ☐ Male

InterRAI CHA/InterRAI-HC Completed: ☐ Yes ☐ No **Date Completed:**

Emergency Contact

Name:	**Phone:**	**Relationship:**	**Caregiver:** ☐ Yes ☐ No	**Call Emergency Contact for DOE/Admission:** ☐ Yes ☐ No

Additional Information

****Health Information/Medical Diagnosis:**

What services does client currently receive? (Including family, friends and private pay)

What is the reason for the referral to SMILE?

The senior has the following unmet needs *(senior must have unmet needs)*:

☐ Meal Prep ☐ Shopping ☐ Housekeeping ☐ Laundry ☐ Outdoor Chores ☐ Transportation ☐ Foot Care ☐ Respite ☐ Security Checks

Referral Information

Referral Source:

☐ Physician
☐ Family Health Team
☐ Community Health Centers
☐ Other: Please Specify:
☐ Frontenac Drs
☐ Nurse Practitioners
☐ Paramedicine

Hospital Referral:

☐ Emergency Department
☐ Reason for ED visit/hospitalization:

Additional Information:

Person completing this form: _____
(Print Name)

Date: _____ **Phone Number:** _____

****Ensure Health Information/Medical Diagnosis section is filled out before summitting this form to SMILE**

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RESET

Ontario
South East Local Health Integration Network
Réseau local d'intégration des services de santé du Sud-Est