



15 Sir Winston Churchill Square 102A Avenue - 100 Street Edmonton, AB T5J 2E5  
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Patient Label

**NP Led Health Services / Social Work Referral Form**

CLIENT INFORMATION			
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____		Client Lives With: <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Alone <input type="checkbox"/> Other: _____	
Primary Care Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No Primary Care Provider			
Name: _____		Address: _____	
Client Secondary Contact: _____		Phone: _____	
Phone: _____		Fax: _____	
If yes, is Primary Care Provider aware of the referral to Sage Seniors Association? <input type="checkbox"/> Yes <input type="checkbox"/> No			

REFERRAL INFORMATION			
Date Referral Completed (mm-dd-yyyy): _____	Referring Provider Name: _____	Phone: _____	Fax: _____
Reason for Referral: <input type="checkbox"/> Referral for Primary NP Provider <input type="checkbox"/> Social Work Support <input type="checkbox"/> Follow-up <input type="checkbox"/> Other: _____			
<input type="checkbox"/> Health System Navigation <input type="checkbox"/> This Full House Hoarding Program (Client Consent to Contact Required)			
Urgency: <input type="checkbox"/> Next Available Appointment <input type="checkbox"/> Urgent			

MEDICAL/SOCIAL INFORMATION

MEDICAL HISTORY		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Arthritis	<input type="checkbox"/> CHF
<input type="checkbox"/> COPD	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Dementia
<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease (CAD, MI, Angina)
<input type="checkbox"/> Stroke	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Osteoporosis	
MEDICAL/PHYSICAL	COGNITIVE/BEHAVIOURAL	PSYCHOSOCIAL
<input type="checkbox"/> Weight Loss/Nutrition	<input type="checkbox"/> Delirium/Hallucinations	<input type="checkbox"/> Caregiver Stress/Family Issues
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Elder Abuse/Neglect
<input type="checkbox"/> Sleep	<input type="checkbox"/> Verbal/Physical Aggression	<input type="checkbox"/> Social Isolation
<input type="checkbox"/> Polypharmacy	<input type="checkbox"/> Wandering	<input type="checkbox"/> Home Safety
	<input type="checkbox"/> Behaviour/Disruptions	<input type="checkbox"/> Financial/Income Security

**Documents Attached:**

List of Medications (BPMH)

Emergency chart

Goals of Care (if complete)

**Client is aware & agreeable to Referral:**

YES  NO

PATIENT MUST CONFIRM CONSENT WHEN CONTACTED