Hospice Orillia
"It's all about living..."

169 Front Street S, Orillia, ON L3V 4S8
Bus: 705-325-0505 | Fax: 705-325-7328
www.hospiceorillia.ca

Referral Intake Form

Date: _____ Referred By: _____

Organization: _____

Phone & ext.: _____

Patient/Client Name: _____

Address: _____

Street Room # City Postal Code

Telephone: _____

Email: _____

Date of Birth: _____ (D/M/Y)

Diagnosis: _____

Would you be surprised if the person died in the next year? Yes No

Physician: _____

Primary Caregiver or Next of Kin: _____

Phone: _____ Address: _____

Is the client aware that the referral to Hospice is being made?

Yes No Other (please explain): _____

Other Information:

_____

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