Hospice Orillia
"It's all about living…"

Referral Intake Form

Referral Information

Referred by: _____ Date: _____

Organization: _____ Phone: _____

Client Information

Name: _____ Date of Birth: _____ (DD/MM/YY)

Phone: _____ Email Address: _____

Address: _____

Street Apt # City Postal Code

Current Location: Home ☐ Other (please provide details): _____

Family and/or Caregiver Information:

Name	Relationship	Contact

Medical Information

Diagnosis: _____

Is client aware of diagnosis? ☐ Yes ☐ No Is family aware of diagnosis?: ☐ Yes ☐ No

Anticipated prognosis: _____

Is client aware of prognosis? ☐ Yes ☐ No Is family aware of prognosis? ☐ Yes ☐ No

Health Care Provider Information:

Provider/Agency	Contact Information	Comments

Is the client aware that the referral to Hospice is being made? ☐ Yes ☐ No

Other Information:

_____

_____

_____

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