



# Referral Form

This form can be completed as a self-referral or by a health-care professional, family member, caregiver or friend. Please provide as much information as possible to help with the referral process.

## Referral Information

Name of person to receive support: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

Age/DOB: \_\_\_\_\_ Language: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Physical Home Address: \_\_\_\_\_

Name & Contact of Family Member/Caregiver: \_\_\_\_\_

Medical diagnosis: \_\_\_\_\_

Current Location of person: Home  Hospital  Long Term Care Facility  Other

Hospital/Facility Name & Room Number: \_\_\_\_\_

If Known:

Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Home Health Nurse: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Social Worker: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## Referral Source (if not a self-referral)

Name and Relationship to person:

Phone number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Would you like us to contact you prior to meeting with the person referred? Yes  No

# Type of Support Requested

Palliative/end-of-life hospice support  Bereavement support

Is this person aware of this referral? Yes  No

If not, please briefly explain why not: \_\_\_\_\_

\_\_\_\_\_

Who should we contact regarding this referral?

The person directly  The person making the referral  Other

If other please provide full name and contact information:

\_\_\_\_\_

\_\_\_\_\_

Is there any other information you would like to share that could be relevant to the clients care or for compatibility with a volunteer? (for eg. social history, family relationships, interests, likes, dislikes, other languages spoken)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Initial here to declare the information provided is accurate & complete \_\_\_\_\_

Your Signature  _____
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Scan & send to elkvalleyhospice@gmail.com
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Submissions will be directed to the Coordinator through the confidential Elk Valley & Area Hospice email account ([elkvalleyhospice@gmail.com](mailto:elkvalleyhospice@gmail.com)). This inbox is checked regularly however, if this referral is urgent, please call us at 250-423-4453 ext 38109 and leave a message. Our goal is to return your call within 48 hours.

Referrals can also be sent via mail to: Elk Valley & Area Hospice, Box 670, Fernie, BC V0B 1M0 or hand delivered to the secure mailbox located on the door of the Kiosk at Elk Valley Hospital.