Shuswap Hospice Society

Ste #4 – 781 Marine Park Dr. NE, Salmon Arm, BC V1E 2W7

PHONE: 250-832-7099 **FAX:** 250-832-7017

EMAIL: programs@shuswaphospice.ca

Client Referral Form

PLEASE PRINT

Referred by: (hospital; Bastion; other facility or agency)_____

Person Referring (from agency above)_____ **Phone:** _____

Date of Referral: _____**Family Physician:** _____

Please send confirmation email when client has been contacted ☐

Email address for referral follow-up confirmation: _____

CLIENT:

Name: _____ **Phone:** _____ ☐ **ok to leave messages**_____**(initial)**

Address: _____**Age :** _____

Present Location: _____**Rm**_____

DIAGNOSIS: _____ **VAX STATUS:**_____

EMAIL: _____ ☐ consent to receive email updates **Faith/Belief:** _____

Referral Type: ☐ **Palliative** ☐ **Grief** ☐ **Companion**

☐ **Children & Youth** ☐ **Nav-Care**

Comments: PLEASE PRINT

_____

_____

_____

_____

Client aware of referral? YES ☐ **NO** ☐ **Client Signature:** _____

Family aware of the referral? YES ☐ **NO** ☐

Signature of parent or guardian if client is under 18 years of age: _____

SUPPORT INFORMATION:

Primary Support Person _____

Relationship: _____ **Phone number:**_____

Volunteer/Staff Assigned: _____

FAX COMPLETED FORM TO: 250-832-7017

Please notify the Hospice Society upon the DEATH OR RELOCATION of the above individual