Shuswap Hospice Society

Suite #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 INFORMATION:

NAME: _____ PHONE: _____

☐ OK to leave messages_____(initial)

ADDRESS: _____ AGE: _____

PRESENT LOCATION: _____ ROOM: _____

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 referral? ☑ YES ☐ NO

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

SUPPORT INFORMATION:

Primary Support Person: _____

Relationship: _____ Phone: _____

Volunteer/Staff Assigned: _____

FAX COMPLETED FORM TO: 250-832-7017

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