

**Instructions:**

1. \* Mandatory fields
2. Attach orders (if required)
3. Signature required before submission

**Home and Community Care Access Lines**

Vancouver (604) 263-7377 | Fax (604) 267-3419  
 Richmond (604) 675-3644 | Fax (604) 278-4713  
 North Shore (604) 983-6700 | Fax (604) 983-6886

Referral Source Information			
Referrer Name			
*LAST	*FIRST	*RELATIONSHIP TO CLIENT	
*PHONE NUMBER	*FAX NUMBER	EMAIL	
Has the client or alternate decision maker given consent for this referral? <input type="checkbox"/> YES <input type="checkbox"/> NO *if no, please explain:		PRIMARY CARE PROVIDER (if applicable)	
Client Information			
*LAST (Legal)	*FIRST	MIDDLE	
*DATE OF BIRTH (YYYY/MM/DD)	*PERSONAL HEALTH NUMBER	*SEX	
*MARITAL STATUS	INDIGENOUS IDENTITY	*GENDER IDENTITY	
*PRIMARY LANGUAGE	*INTERPRETER REQUIRED <input type="checkbox"/> NO <input type="checkbox"/> YES		
*ADDRESS (Unit#/ Buzz#)	*CITY	*POSTAL CODE	*PROVINCE
*PRIMARY PHONE NUMBER	*SECONDARY PHONE NUMBER	EMAIL	
*ALTERNATE CONTACT NAME	*RELATIONSHIP TO CLIENT	*ALTERNATE CONTACT PHONE NUMBER	
*REFERRAL: <input type="checkbox"/> URGENT <input type="checkbox"/> NON-URGENT		ALTERNATE CONTACT EMAIL	
Reason for Referral to Home Health <i>(see back of referral form for Home Health Services that require orders or Treatment plan)</i>			
*What specific change or event has led to initiating this referral? <input type="checkbox"/> Orders or treatment plan completed, signed and attached			
*Relevant Medical History/Conditions (e.g. cognition, functional status, etc) <input type="checkbox"/> see attachment(s) e.g. Medical Summary			
*Allergies <input type="checkbox"/> NO <input type="checkbox"/> YES <i>*if yes, please list</i>			
Palliative Home Health Services <i>(complete this section if the client would benefit from a palliative care approach)</i>			
<input type="checkbox"/> B.C. Palliative Care Benefits signed <input type="checkbox"/> CPR form completed		<input type="checkbox"/> Advanced Care Planning (ACP) <input type="checkbox"/> Goals of Care (GOC)	
Referring Medical Provider SIGNATURE			
*PRINT NAME	*SIGNATURE	DATE (yyyy/mm/dd)	

## HOME HEALTH SERVICES

Home Health Services are offered to clients and/or caregivers for the purposes of restoring or maintaining independence in the home and include:

- Case Manager
- Community Health Nurse
- Ambulatory Care Nursing (services provided in a clinic setting)
- Occupational Therapist
- Physiotherapist
- Social Worker
- Dietician
- Speech Language Therapist
- Spiritual Health Practitioner

Once your client is connected with Home Health, the Home Health clinician may connect them with the following programs if needed:

- Home Support
- Overnight Respite
- Palliative, End of Life & Hospice Care
- Choice in Supports for Independent Living (CSIL)
- Adult Day Programs
- Family/Caregiver Support
- Speech-Language Pathology & Swallowing Assessment Services
- Long Term Care, Assisted Living

## ORDERS

The following Home Health services require an order from an authorized prescriber (attach complete orders with the referral):

- Catheter Care
- Trial of Void
- Management of drains or tubes
- Tracheostomy management
- IV Therapy

## TREATMENT PLANS

Treatment plans are accepted for the following interventions (Note: Treatment Plans are optional):

- Wound Care
- Mobility
- Continence management (including ostomy)
- Pain management through measures other than medication (e.g. positioning, movement)