BethellHospice

REFERRAL FORM

Community Program Referral ☐ **Hospice Residence Referral** ☐

Referral Source:

Name of Referree: _____ Organization (if applicable): _____

Date:_____ Relation/Title: _____ Phone: _____ Email:_____

Personal Information

Name:_____

Date of Birth (MM/DD/YY):_____ Gender:_____ Email: _____
Home Address: _____ City:_____ Postal Code:_____
Home Phone:_____ Cell Phone: _____

Emergency Contact Person:

Name: _____ Relation: _____ Phone: _____

Client Type:

Client with Palliative Care Needs ☐ Caregiver Client ☐ Bereaved Client ☐

If requesting Palliative Client Services, please complete the section below:

Diagnosis: _____ Date of Diagnosis: _____ PPS (if known): _____

Physician/Nurse Name: _____ Title: _____ Phone: _____

If requesting Caregiver Client Services, please complete the section below:

Name of Person Being Cared For: _____ Diagnosis: _____ Relation: _____

If requesting Bereavement Client Services, please complete the section below:

Name of Deceased: _____ Date of Death:_____ Relation:_____

Additional Notes:_____
_____
_____

Please complete the form and submit via. fax or email to:

Dorothy Rankin, Intake Coordinator, Fax: 905-838-0302, Email: intake@bethellhospice.org

Natalie Talma, Community Team Lead, Fax: 905-838-0302, Email: communityintake@bethellhospice.org