Arirang Age-Friendly Community Centre
아리랑 시니어 센터

REFERRAL FORM FOR CHATS at Arirang ADULT DAY PROGRAM

CHATS Community & Home Assistance to Seniors

Please fax completed referral to: 905-713-1705 **Attention: CHATS at Arirang Adult Day Program**

Date referral completed (DD/MM/YY): _____

CLIENT INFORMATION

Full Name: _____
Full Address:
_____
_____

Tel.:_____ **Alt. Tel.**: _____
OHIP #: _____ **VC:** _____ **Date of Birth** (DD/MM/YY):_____

Primary Contact:
☐ Same as above
☐ Other (see below)
Name: _____
Telephone Number: _____
Relation: ☐Spouse ☐ Daughter ☐ Son ☐ DIL ☐SIL ☐Other: _____

Reason for Referral (tick all that apply):
☐ Frail ☐ Socially Isolated ☐Wellness & Exercise ☐Cognition
☐ Other (please note): _____

Urgency for program entry: ☐Non-urgent ☐Urgent

PHYSICIAN INFORMATION

Referring Physician:
Physician's Name: _____
Address: _____
Tel.: _____

Attending Physician:
Physician's Name: _____
Address: _____
Tel.: _____

☐ My physician has advised me that this referral is not deemed to be an automatic acceptance into the CHAT at Arirang Adult Day Program. There will be a site visit conducted with the Adult Day Program Supervisor prior to acceptance. By signing below the client/caregiver agrees this information will be shared with CHATS and Arirang.

_____ _____
Physicians Signature / Date **Signature client or Primary Contact / Date**

Other Pertinent Information:
_____
_____
_____
_____

----TURN OVER----

MEDICAL INFORMATION	
Primary Diagnosis	
Secondary Diagnosis	
Prognosis	☐Improve ☐Deteriorate ☐Remain Stable ☐Maintenance
Diagnosis Discussed	With client □ Yes □ No With caregiver □ Yes □ No
Prognosis Discussed	With client □ Yes □ No With caregiver □ Yes □ No
Relevant Medical History	
Surgical Or Other Procedure(S)	
Medication	Please **attach** a current list of all medications including: •Medication Name •Dosage •Frequency •Route •Duration
Diet	☐Regular ☐Diabetic ☐ Minced ☐Puree ☐Low Salt ☐Other _____ ☐Dentures:☐Upper ☐Lower ☐Chewing/Swallowing Issues Other Food Preferences:
Allergies	Food: _____ Medication: _____ Environmental: _____
Mobility	☐No Assistive Devices needed☐ Cane ☐Walker ☐Wheelchair ☐Other_____
Washroom	☐Independent ☐Requires Assistance
Transfers	☐Independent ☐ Independent with supervision ☐Needs one person assistance ☐Needs two person assistance
Urinary Continence	☐No Control ☐Some Control ☐Complete Control
Bowel Continence	☐No Control ☐Some Control ☐Complete Control
Hearing	☐No hearing problems ☐Some difficulty ☐Difficulty Hearing ☐Wears Hearing Aid
Vision	☐No vision problems ☐Some Vision problems ☐Visually Impaired ☐Wears glasses all the time ☐Wear glasses for reading ☐Wears glasses for distance
Pain	☐No pain ☐Minor ☐Constance: List pain site(s)_____
Behavioural	☐Wandering ☐Exit Seeking ☐Anxiety ☐Verbally Aggressive ☐Physically Aggressive
Height _____	**Weight_____**
Skin Issues	☐Ulcers ☐Other _____
Smoker	☐Yes ☐No
Oxygen	☐Yes ☐No
Infection Control (TB/MRSA/VRE/RSV) Etc.	☐No Concerns ☐ Yes; please describe _____