GREATER TRAIL HOSPICE SOCIETY

Office: 250-364-6204 **After Hours Cell:** 236-968-6642
Fax: 250-364-6218
Kiro Wellness Center, # 7- 1500 Columbia Ave, Trail, BC, V1R 1J9

Hospice Referral Form

CLIENT NAME: _____ Prefers to be called: _____

Birth Date: _____ Age: _____ Marital Status: _____

Address: _____ City: _____

Phone: _____ Postal Code: _____

Current Location:
- ☐ KBH, Room#_____ Bed# _____:
- ☐ CVL ☐ Poplar Ridge ☐ Rosewood Room #: _____ Bed#_____
- ☐ Home (at address above)
- ☐ Other:

Diagnosis: _____

Palliative Performance Scale: _____% **Are client / family aware of this referral?** ___Yes ___No

Special Precautions, (e.g. infection control issues; mobility issues, pets in home, allergies, etc).

_____

Does this Client identify as ☐ **Veteran** ☐ **Indigenous** ☐ **LBGTQ2S**

Contact Information

Primary Contact: _____ Relationship: _____

Phone: HOME/CELL/WORK _____

Referral Requested ☐ Urgent (1-2 days) ☐ Non-urgent (3-14 days)

- ☐ Friendly Visitor
- ☐ Bedside Volunteer
- ☐ Nav-CARE program
- ☐ Spiritual Care

Date of Referral: _____ Phone Number: _____

Source of Referral _____
NAME AND TITLE/DESIGNATION OF PERSON MAKING REFERRAL

All Information on this form is strictly personal and confidential and for exclusive use by the Greater Trail Hospice Society

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CLIENT NAME: _____

PLEASE FILL OUT PERSONAL INFORMATION ON THE OTHER SIDE OF THIS FORM

Information that will help care for this client more personally: (Likes or dislike. Relationship with family or friends. Work or travel experience. Strong faith or religious beliefs. What else would bring comfort to this person?)

Intake Notes:

Comments: _____

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