London InterCommunity Health Centre

Seniors' WrapAround Program
Referral Form

Date: ________________________________

Name of Client: ____

Address: _______________________________________ Phone Number: ________________________

Alternative contact information: ____

Referring Agency: _____________________________________

Referred by: _________________________ Phone: _________________________ Fax: ________________

Reason(s) for the referral: ____

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Please check any that may apply to this referral based on your awareness and understanding of the senior:

- ☐ Age __________
- ☐ Social isolation
- ☐ Limited family/social support
- ☐ Mobility Issues
- ☐ Low income
- ☐ Mental health Issues ____
- ☐ Senior's caregiver burnout/stress
- ☐ None or limited communication skills in English Preferred language _____________________________

Medical conditions ____

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Living conditions/environment ____

Safety Risk to a provider Yes ☐ No ☐ Unknown ☐ ____

Services involved: ____

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Client consent to make the referral:

I agree to have my name and contact information released to the London InterCommunity Health Centre, Seniors' WrapAround Program.

Name: ______________________________________ Signature: ___________________________________