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: _____

_____

_____

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

☐ Age _____ DOB _____ OHIP # _____

☐ 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 _____

_____

Living conditions/environment _____

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

Services involved: _____

_____

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: _____