

Client Health Record #  
Client Surname  
Given Name  
Date of Birth  
Gender  
MFRN  
PHIN  
Address (home visits only)

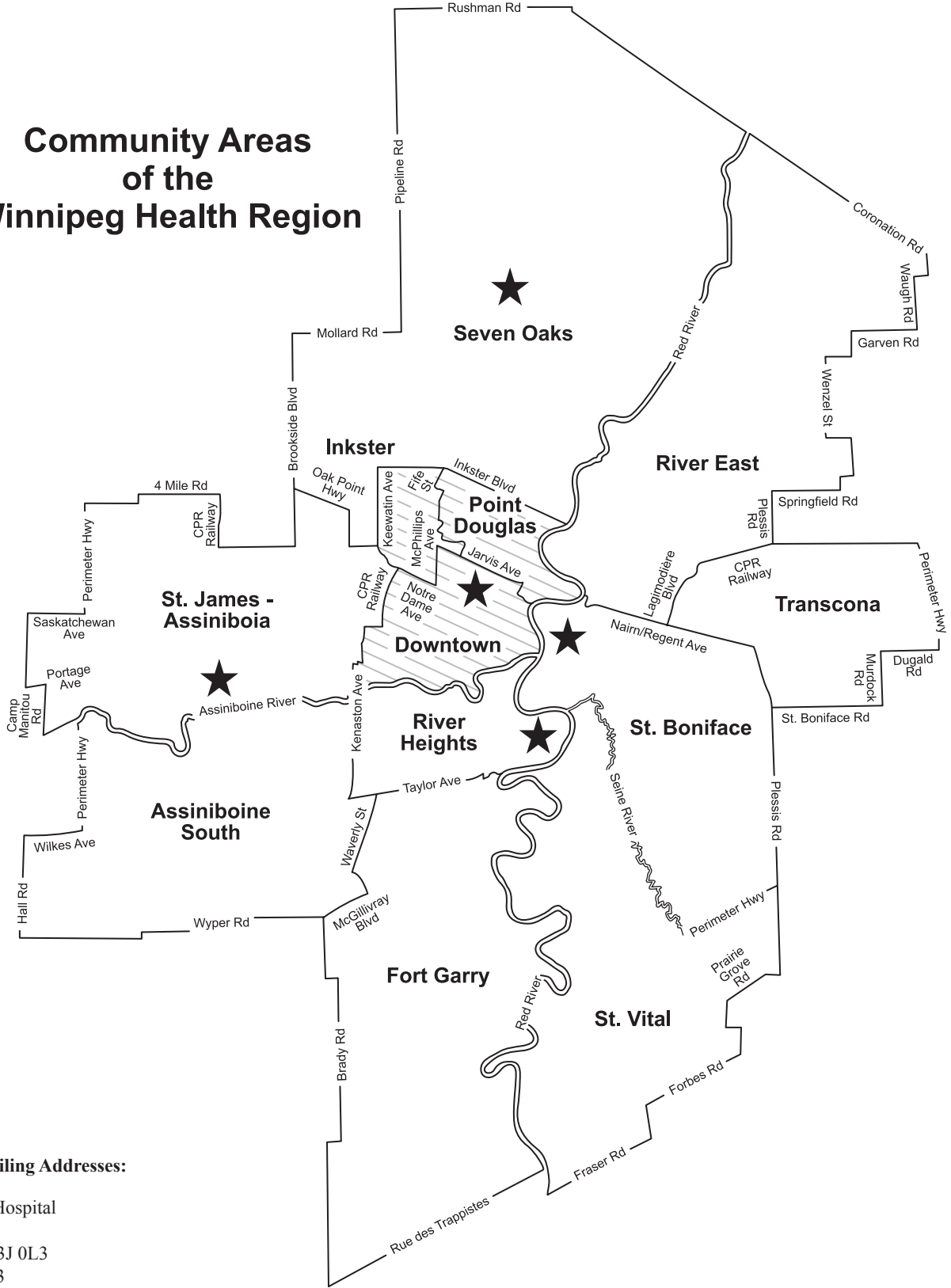
# DAY HOSPITAL REFERRAL

Complete all sections of the form and forward **with required information** to:

- Deer Lodge Day Hospital ..... (Fax 889-6871)
- Riverview Day Hospital ..... (Fax 284-5386)
- Seven Oaks Day Hospital ..... (Fax 632-8896)
- St. Boniface Day Hospital ..... (Fax 237-6674)
- Health Services for the Elderly ..... (Fax 940-8731)

CLIENT INFORMATION	NAME OF CLIENT			LANGUAGE			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
	ADDRESS				POSTAL CODE		PHONE #	
	DATE OF BIRTH			MHSC		PHIN		
	DD	MMM	YYYY					
CONTACT PERSON					RELATIONSHIP		PHONE #	
HEALTH AGENCIES	PHYSICIAN				PHONE #		FAX #	
	HOME CARE COORDINATOR				PHONE #		FAX #	
	OTHER AGENCIES INVOLVED/CONSULTED: (Check all that apply)							
	<input type="checkbox"/> GERIATRIC PROGRAM ASSESSMENT TEAM				<input type="checkbox"/> GERIATRIC MENTAL HEALTH			
<input type="checkbox"/> COMMUNITY THERAPY SERVICES				<input type="checkbox"/> OTHER _____				
1) Name: _____			Address: _____			Phone #: _____		
Service Provided: _____								
2) Name: _____			Address: _____			Phone #: _____		
Service Provided: _____								
CLINICAL INFORMATION	DIAGNOSIS/ACTIVE PROBLEMS							
	PAST MEDICAL HISTORY							
	RECENT HOSPITALIZATIONS							
	CURRENT MEDICATIONS (Attach up-to-date list or annotated DPIN)				ALLERGIES		DIET	
	REASON FOR REFERRAL (What issues need to be addressed?)							
	IS IT URGENT? IF YES, WHY?							
	REQUIRED INFORMATION (attach all relevant results, if available):							
	<input type="checkbox"/> SCAN/X-RAY (WITHIN LAST 6 MONTHS)				<input type="checkbox"/> OCCUPATIONAL THERAPY/PHYSIOTHERAPY ASSESSMENT			
	<input type="checkbox"/> RECENT EKG				<input type="checkbox"/> SPECIALIST ASSESSMENTS/CONSULTATIONS/DISCHARGE SUMMARIES			
	<input type="checkbox"/> ANY OTHER APPROPRIATE LAB VALUE				<input type="checkbox"/> SOCIAL INFORMATION			
PATIENT IS AWARE AND IN AGREEMENT WITH THIS REFERRAL <input type="checkbox"/> YES <input type="checkbox"/> NO      PHYSICIAN AWARE <input type="checkbox"/> YES <input type="checkbox"/> NO								
NAME OF REFERRING AGENCY			REFERRAL COORDINATED BY			PHONE #		
SIGNATURE OF REFERRING SOURCE					DATE OF REFERRAL			
					DD	MMM	YYYY	

# Community Areas of the Winnipeg Health Region



**Day Hospital Mailing Addresses:**

Deer Lodge Day Hospital  
 2109 Portage Ave  
 Winnipeg, MB R3J 0L3  
 Phone #: 831-2583

Health Services for the Elderly  
 425 Elgin Ave  
 Winnipeg, MB R3A 1P2  
 Phone #: 940-1637

Riverview Day Hospital  
 1 Morley Ave  
 Winnipeg, MB R3L 2P4  
 Phone #: 478-6262

Seven Oaks Day Hospital  
 2300 McPhillips Street  
 Winnipeg, MB R2V 3M3  
 Phone #: 632-3106

St. Boniface Day Hospital  
 69B Goulet Street  
 Winnipeg, MB R2H 0R5  
 Phone #: 953-6400

Catchment Areas	
DLC:	St. James-Assiniboia & Assiniboine South
HSE:	Inkster, Point Douglas & Downtown
RHC:	River Heights & Fort Garry
SBGH:	Transcona, St. Vital & St. Boniface
SOGH:	River East & Seven Oaks, Inkster