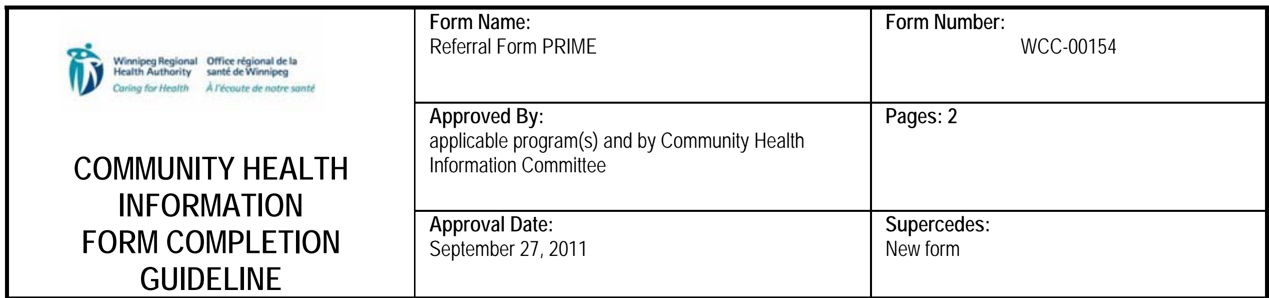


Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg — Caring for Health / À l'écoute de notre santé COMMUNITY HEALTH INFORMATION FORM COMPLETION GUIDELINE	**Form Name:** Referral Form PRIME	**Form Number:** WCC-00154
	Approved By: applicable program(s) and by Community Health Information Committee	**Pages:** 2
	Approval Date: September 27, 2011	**Supercedes:** New form

INTENT/PURPOSE OF FORM

- To provide accurate and consistent referral information to PRIME
- To facilitate effective decision making regarding referrals to PRIME

DEFINITIONS

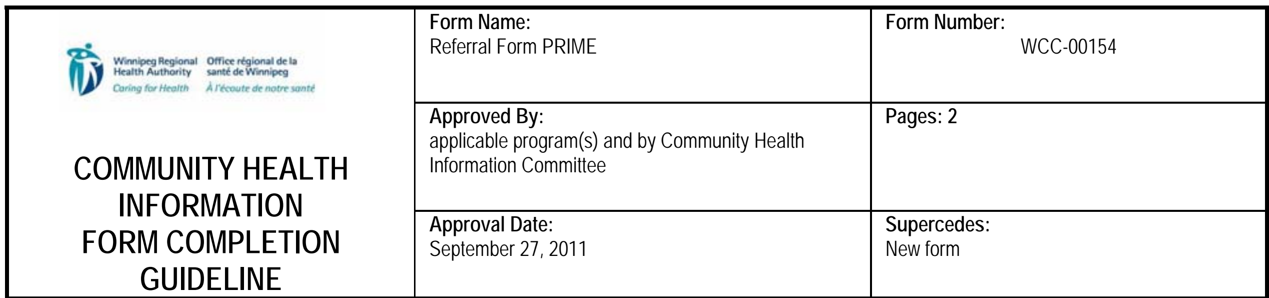
- Referral: Request for the recipient of the referral to assume aspects of an individual's care
- PRIME: A Health Centre for Seniors: An all inclusive program of care for community dwelling frail elderly with chronic and complex health issues aimed at supporting seniors in community living
- Primary Contact: informal care provider

USED BY

- Any program, agency, health service, family or individual making a referral

GUIDELINES FOR COMPETION OF FORM

- **Upper right box:** Addressograph or label may be used
- **REFERRER box:**
- Date of referral: date form is complete
- Referred by: name of individual responsible for the referral
- Agency/program: name of the agency/program the referrer is representing. For self or family referrals enter relationship to individual being referred.
- Signature: Signature of individual named in 'referred by' field
- Fax: fax number of individual named in 'referred by' who will receive a fax confirmation of PRIME's receipt of referral
- Phone: phone number of individual named in 'referred by' field
- **CLIENT INFORMATION box:**
- Address: Regardless of the client's location at the time of the referral, ie. hospital, this is for the home address in community where client resides
- Postal code: at client's home address
- Phone number: at client's home address
- Language: may check both 'English' and 'Other' as necessary
- In Hospital: Indicate 'yes' only if referral is being made while client is admitted to a health care facility, and for 'Site/Unit' field provide information regarding facility name and unit client is admitted to. Check 'no' if client is either not in a facility or is in the Emergency Dept.
- **TO DISCUSS REFERRAL CALL box:**



COMMUNITY HEALTH INFORMATION FORM COMPLETION GUIDELINE	Form Name: Referral Form PRIME	Form Number: WCC-00154
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- Client: refers to individual named in 'Upper Right box'
- Primary Contact: individual, other than client and referrer, who is considered the client's informal care provider, if available.
- Phone: of primary contact
- Relationship: of primary contact to the client being referred
- Has client been advised of referral?: check one box
- Is primary contact aware of referral?: check one box
- **PROGRAMS/OTHERS INVOLVED box:**
- Family physician, phone, fax: name, phone and fax of primary care physician in community for client
- Home Care Coordinator, phone, fax: whether in hospital or at home, enter name of community case coordinator.
- Home Care Coordinator agrees with referral?: It is preferable, but not mandatory, that this referral is discussed with the client's case coordinator. Explain if 'no' is checked.
- Others involved (attach reports): check as many as necessary, and include any relevant reports and summaries.
- **HEALTH INFORMATION :** include relevant information impacting on client's current health status and situation
- **REASON FOR REFERRAL TO PRIME:** In referrers own words describe the client's situation and why PRIME would be of benefit to the client.
- **Hospitalizations and Emergency visits:** include information on the nature of the hospital visits

FILING/ROUTING INSTRUCTIONS

- *Filed in 'Client Information' section of chart*

PRINTING INSTRUCTIONS

- Single forms can be printed from Insite
- The form is one sided

AUTHOR:

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