



REFERRAL FORM

PRIME: A Health Centre for Seniors

Deer Lodge Centre
2109 Portage Avenue (entrance at 203 Duffield)
Winnipeg, MB, R3J 0L3
Phone: (204) 833-1700 Fax: (204) 940-2125

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

Date of referral: _____
Referred by: _____ Program/Agency: _____
Signature: _____ Fax: _____ Phone: _____

Note to Referrer: You will receive a fax confirmation of PRIME'S receipt of your referral within 1 business day.

CLIENT INFORMATION:

Address: _____ Postal Code: _____
Phone Number: _____ Language: English Other: _____
In Hospital: No Yes, Site/Unit: _____

TO DISCUSS REFERRAL CALL: CLIENT or PRIMARY CONTACT

Primary Contact: _____ Phone: _____ Relationship: _____
Has client been advised of referral? YES NO Is primary contact aware of referral? YES NO

PROGRAMS/OTHERS INVOLVED:

Family Physician: _____ Phone: _____ Fax: _____
Home Care Coordinator: _____ Phone: _____ Fax: _____
Home Care agrees with referral? Yes No, Reason: _____
Others involved (attach reports): Geriatric Mental Health Geriatric Program Assessment Team Day Hospital
 Community Therapy Services Adult Day Program
 Other: _____

HEALTH INFORMATION (Current and Past Medical History/Active Problems/Medications/Diagnostics):

REASON FOR REFERRAL TO PRIME (Describe the client's situation and what your expectations of PRIME are):

Hospitalizations and Emergency visits PAST 6 MONTHS (Describe/ include dates & locations):

