LIVING WITH ADVANCED ILLNESS REFERRAL FORM

Living with Advanced Illness Centre

Date of Referral (M/D/Y): _____

Contact Information:

Client's Name: _____

Address: _____

City: _____

Postal Code: _____

Date of Birth (MMM/DD/YYYY): _____

Home Phone Number: _____ Cell: _____

Email: _____

Relationship to the person with the Advanced Illness: _____

Is the referred client living with the person with advanced Illness? ☐ Yes ☐ No

Referred by: _____

Clinic/Service/Organization: _____

Address: _____

Phone number: _____

Fax number: _____

Email (to send confirmation of referral received): _____

Indication for Referral:

What is the Client's Diagnosis: _____

Estimated Prognosis (to support triage): _____

Referral Reason: (check all that apply)

☐ Seeking support for myself
☐ Seeking support as a caregiver
☐ Seeking support as a close person to the individual with an advanced illness
☐ Seeking support for children (19 years and under):
Ages of the children: _____

The person with the advanced illness:

☐ Lives independently
☐ Lives in continuing care:
☐ Home Care ☐ Assisted Living ☐ Long Term Care ☐ Hospice

Is there any additional information that would support the Counsellor with the initiation of this referral?

_____

Please **Fax** this referral to **403-263-4524**

For more information, please contact the Intake Coordinator at 403-263-4525.

Children's Grief Centre | Living with Advanced Illness Centre | Rosedale Hospice

September 2023