RITE SERVICE REFERRAL FORM

Attention: Community Gateway/Intake
Phone: 613-238-8420 Fax: 613-238-1306

VHA Health & Home Support / Soins et soutien à domicile
Wellness for everyday living / Pour un mieux-être

REFERRAL SOURCE *(Person completing this form)*			
Referred by:		Program/Agency/Hospital:	
Phone:	Ext:	Fax:	E-mail:
Date of referral: *(MM/DD/YY)*		To discuss referral call: ☐ Applicant	☐ Alternate contact

APPLICANT INFORMATION			
Name: (Last)	(First)	D.O.B. *(MM/DD/YY)*	
Gender: ☐ F ☐ M ☐ Non-binary		Ontario Health Card #:	
Permanent Address:	Unit #:	City	Postal Code
Home #:	Cell #:	E-mail:	
Preferred language for service: ☐ English ☐ French			
Applicant is aware of referral: ☐ Yes ☐ No			

ALTERNATE CONTACT			
Name: (Last)	(First)	Home #: Cell #:	Relationship:
Alternate contact is aware of referral: ☐ Yes ☐ No ☐ Not applicable			

CURRENT SERVICES/SUPPORTS			
☐ ADP	☐ ALS/HRS	☐ Going Home Program	☐ Home & Community Care
☐ Community Support Services *(PSS, HM, MOW, Respite, Supportive Housing etc):*			
☐ Other *(Please specify):*			

HEALTH CONDITIONS				
☐ Arthritis	☐ Cerebral Palsy		☐ COPD	☐ Congestive heart failure
☐ Dementia/Cognitive decline	☐ Diabetes	☐ Spina Bifida	☐ Spinal Cord Injury	☐ Stroke
Chronic progressive diseases: *(ALS, MS, MD)*				
Other *(Please specify): Examples include hearing impairment, mental health, visual impairment)*				

REASON FOR REFERRAL
Describe applicant's current situation & support needs:
☐ Transition from hospital/convalescence/respite ☐ Discharge summary attached
☐ Health system navigation *(addressing medical & social determinants of health)*
☐ Other:

Last Update: Apr 2023

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ADDITIONAL INFORMATION			
☐ Aggressive behaviour	☐ Hoarding	☐ Infestation	☐ Infectious diseases requiring additional precautions *(Please specify):*

For completion by RITE Team (Internal use only)	
Date Received:	**Signature, Manager Community Gateway**