SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Health Record #: _____ Complete or place barcoded patient label here
Patient Name: *(Print first, last)* _____
DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Account #: _____ Date of Admission: dd / mm / yy

Complex Continuing Care Referral

Date of Referral to Complex Care: dd / mm / yy	**From:**	**Ext.**
Acute Admit Date: dd / mm / yy	**Admitted from:** ❑ Home ❑ Retirement Home ❑ Nursing Home ❑ Other	
Family Physician Name: *(print first, last)*		
Consults this admission:		
Admitting DX:	**Current DX:**	
Medical HX:		
Surgical HX:		
CONTRIBUTING COMPLEX FACTORS *(ie, IV medications, IV feeding/enteral, tracheostomy, ventilator, ulcer care: stages 3-4, pressure release devices, complex dressings)*		
MRSA: Date: dd / mm / yy ❑ Pos ❑ Neg	**C-Diff: Date:** dd / mm / yy ❑ Pos ❑ Neg	
Advanced directives on chart: ❑ No ❑ Yes - List _____		
Medical Status: Patient is medically/surgically stable. ❑ Yes ❑ No		
Has there been any significant change in the last 3 days? ❑ Yes ❑ No Explain: _____		
Has patient been seen by primary physician in the last 3 days and confirms patient is stable? ❑ Yes ❑ No		
PREVIOUS FUNCTIONAL STATUS/HISTORY OF PATIENT		
Mobility:	Continence:	
Cognitive Status:		
Social situation: Family/Caregiver:		
Community Support:		
Patient/Family Goals/Expectations:		
Recommendations/Comments/Team Plans:		
_____		
_____		
_____		
Reviewed and agreed on by Patient Signature:		
Reviewed and agreed on by Family Signature:	**Date:** dd / mm / yy	

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Complex Continuing Care Referral

Case conference held:	
If LTCF indicated, please attach PCS applications.	
A.L.C. date designated: dd / mm / yy	**Co-payment Date:** dd / mm / yy
Other Discharge Plans:	
Primary Contact Person(s)	
1. Name: *(print first, last)*	
Address:	
Home Phone #:	**Bus. Phone #:**
2. Name: *(print first, last)*	
Address:	
Home Phone #:	**Bus. Phone #:**
POWER OF ATTORNEY: Financial: ❑ Yes ❑ No	**Personal:** ❑ Yes ❑ No
Discipline:	**Date:** dd / mm / yy
SW/DP	**NURSING**
PT	**OT**
SLP	**DIETITIAN**
***NOTE: Attach a copy of LTCF application with this referral.**	
"Functional Assessment Placement Co-ordination Services" (pink form) is attached even if LTCF application not applicable.	

BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL

Name: *(print first, last)*	
Signature:	**Date:** dd / mm / yy **Time:** _____

FOR COMPLEX MEDICAL REHAB USE ONLY	
Report received by Name: *(print first, last)*	**Date:** dd / mm / yy **Time:** _____
Report taken by Name: *(print first, last)*	**Date:** dd / mm / yy **Time:** _____
Date referral received: dd / mm / yy	**APPOINTMENT – Date:** dd / mm / yy **Time:** _____

SL1040_03 (11/18) "Complex Continuing Care" Review (11/21)