Greater Trail Hospice Society

Kiro Wellness Center, #7-1500 Columbia Avenue, Trail, BC, V1R1J9
Office: 250-364-6204 **Fax:** 250-364-6218 **After Hours Cell:** 236-968-6642

Hospice Client Referral Form

Client Name: ______________________ Preferred Name: ______________________

Birth Date: ______________________ Phone: ______________________

Address: ____

City: ______________________ Postal Code: ______________________

Current Location:

☐ KBH Room #: __________ Bed #: __________

☐ Rosewood Room #: __________ Bed #: __________

☐ Poplar Ridge ☐ CVL ☐ Home (at address above) ☐ Other

Diagnosis: ____

Palliative Performance Scale: ______ %

Are the Client/Family aware of this referral? ☐ Yes ☐ No

Special Precautions (e.g. infection issues; mobility issues, pets in home, allergies, etc):

____

Does this Client identify as: ☐ Veteran ☐ Indigenous ☐ LGBTQIA+

Contact Information

Primary Contact: ______________________ Relationship: ______________________

Phone: (Home/Cell/Work) ____

All information on this form is strictly personal and confidential and for exclusive use by Greater Trail Hospice Society

Updated June 2024

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Client Name: ______________________________

Referral Requested

☐ Urgent (1-2 days) ☐ Non-urgent (3-14 days)

☐ Friendly Visitor ☐ Nav-CARE Program ☐ Bedside Volunteer

☐ Caregiver Support ☐ Grief Support ☐ Spiritual Support

Date of Referral: ____________________________ Phone: ____________________________

Source of Referral: ____

Information that will help care for this client more personally: (Likes or dislikes, relationship with family or friends, work or travel experience, strong faith or religious beliefs. What else would bring comfort to this person?)

Intake Notes

Goals of Client care from Greater Trail Hospice Society:

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