GREATER TRAIL HOSPICE SOCIETY

Office: 250-364-6204 **After Hours Cell:** 236-968-6642
Fax: 250-364-6218
Kiro Wellness Center, # 7- 1500 Columbia Ave, Trail, BC, V1R 1J9

Hospice Referral Form

CLIENT NAME: ______________________ Prefers to be called: _______________

Birth Date: ________________________ Age: _______ Marital Status: ______

Address: ___________________________ City: ____________________________

Phone: ___________________________ Postal Code: _____________________

Current Location:
- ☐ KBH, Room#______ Bed# ______:
- ☐ CVL ☐ Poplar Ridge ☐ Rosewood Room #: _______ Bed#_________
- ☐ Home (at address above)
- ☐ Other:

Diagnosis: ____

Palliative Performance Scale: _____% **Are client / family aware of this referral?** ___Yes ___No

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

____

Does this Client identify as ☐ **Veteran** ☐ **Indigenous** ☐ **LBGTQ2S**

Contact Information

Primary Contact: ____________________ Relationship: ____________________

Phone: HOME/CELL/WORK ______________________________________

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

- ☐ Friendly Visitor
- ☐ Nav-CARE program
- ☐ Caregiver Support
- ☐ Bedside Volunteer
- ☐ Spiritual Support

Date of Referral: ____________________ Phone Number: ____________________

Source of Referral ____
NAME AND TITLE/DESIGNATION OF PERSON MAKING REFERRAL

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

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CLIENT NAME: ____

PLEASE FILL OUT PERSONAL INFORMATION ON THE OTHER SIDE OF THIS FORM

Information that will help care for this client more personally: (Likes or dislike. Relationship with family or friends. Work or travel experience. Strong faith or religious beliefs. What else would bring comfort to this person?)

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Intake Notes:

Comments: ____

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Revised December 2023