Social Prescribing Referral Form
Edmonton Seniors 55+

Send completed form to: aic@mysage.ca or via fax to: 780-426-5175
Attention: Social Prescribing. Phone Number: 780-809-9411
*This form must be completed by a Registered Healthcare Provider

DATE: _____

REFERRAL MADE BY:

☐ HomeCare/ Home Living ☐ Family Doctor ☐ Hospital ☐ Primary Care Network
☐ Other _____

Full Name: _____Phone #: _____ Fax #: _____
Email: _____HC/ PCN Office: _____

*PLEASE ENSURE: CONSENT TO DISCLOSE HEALTH INFORMATION IS GIVEN PRIOR TO SUBMISSION.
* THE CLIENT IS AWARE OF THE REFFERAL AND AGREES WITH THE REASONS FOR REFERRAL.

CLIENT INFORMATION:

Full Name: _____ Phone #: _____

Address: _____ City: _____Postal Code: _____

Primary Contact if different than the Client: _____

Best time of day to call:_____ Can a message be left? ☐ Yes ☐ No ☐ Unsure

Building Type: ☐ Apartment ☐ House ☐ Other: _____

Date of Birth: _____ **Gender:** ☐Male ☐Female ☐ Gender Diverse (LGBTQ2s+)

Primary Language: _____ Additional Languages: _____

Primary Source of Income (If known): _____

Living arrangements: ☐Alone ☐With Spouse/ Partner ☐ With Roommates ☐ With Dependents ☐ With Extended Family ☐ Experiencing Homelessness ☐ Other _____

Marital Status:☐ Married/ Common Law ☐Separated ☐ Divorced ☐ Widowed ☐Involuntary Separation ☐ Single, never married.

Client is receiving supports through Meals on Wheels?

☐ Yes ☐ No ☐Unsure

Does Client have access to affordable and reliable transportation?

☐Yes ☐ No ☐Unsure

Client Equity Information: Select any/ all that may apply.
☐ First Nations/ Metis/ Inuit ☐ Member of Visible Minority (Non-Indigenous)
☐ Person with Disabilities ☐ Other _____
☐ Ethnocultural community/ Country of origin/: _____
Year arrived Canada: _____

REASON FOR REFERRAL:

Please select all that might apply

- ☐ Navigation of Community Supports & Services
- ☐ Application for Financial benefits
- ☐ Meal Assistance/ Food Security
- ☐ Housekeeping
- ☐ Grocery shopping
- ☐ Assisted Transportation
- ☐ Socialization
- ☐ Housing
- ☐ Legal Assistance
- ☐ Snow Shoveling/ Yard Maintenance
- ☐ Recreation/ Leisure
- ☐ Other _____

SPECIAL CONSIDERATIONS:

Please specify any circumstances for consideration:

- ☐ Cognitive or Memory Challenges
- ☐ Mental Health Issues
- ☐ Physical Mobility
- ☐ Clutter
- ☐ Hearing Impairment
- ☐ Visual Impairment
- ☐ Elder Abuse
- ☐ Grief and Loss
- ☐ Diverse Cultural Need
- ☐ Literacy Support
- ☐ Isolation
- ☐ Caregiver Concerns
- ☐ Health Challenges/ Barriers
- ☐ Other_____

CLIENT HOSPITALIZATION DISCHARGE DATE (if applicable): ___

HealthCare Provider (if Applicable):

Does the client have a consistent primary healthcare provider?

☐ Yes ☐ No ☐ Unsure

Provider Information if known:

Full Name: _____Phone #: _____

Fax #: _____

HOME CARE CASE MANAGER (if Applicable):

Full Name: _____Phone #: _____

Fax #: _____Email: _____

Services Provided: _____

ADDITIONAL SUPPORTS (CAREGIVER, FAMILY, OTHER AGENCYS INVOLVED):

Contact #1 - ☐ Caregiver ☐ Family ☐ Agency ☐ Other: _____

Full Name: _____Relationship: _____

Phone #: _____ Email: _____

Contact #2 - ☐ Caregiver ☐ Family ☐ Agency ☐ Other: _____

Full Name: _____Relationship: _____

Phone #: _____ Email: _____