Social Prescribing Referral Form Edmonton Seniors 55+

Send completed form to: SRX@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: _____

* ☐ Consent to disclose healthcare information has been given prior to submission.
* ☐ Client is aware of the referral and agrees with the reason(s) 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+)

Preferred Language:_____ Additional Languages: _____

Primary Source of Income (If known): _____

Living arrangements: ☐ Alone ☐ With Spouse/ Partner ☐ With Roommates ☐ With Dependents ☐ With Extended Family ☐ Housing Instability ☐ Other _____

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

Are there any identified risks for staff completing home visits? ☐ Yes ☐ No ☐ Unsure If yes, what risks have been identified_____

Client is receiving supports through Meals on Wheels?

☐ Yes ☐ No ☐ Unsure

Does Client have access to affordable and reliable transportation?

☐ Yes ☐ No ☐ Unsure Main form of transportation:_____

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
- ☐ Financial Supports
- ☐ Meal Assistance/ Food Security
- ☐ Housekeeping
- ☐ Grocery shopping
- ☐ Assisted Transportation
- ☐ Socialization
- ☐ Housing
- ☐ Legal Assistance
- ☐ Snow Shoveling/ Yard Maintenance
- ☐ Recreation/ Leisure
- ☐ Other _____

Additional Comments (if applicable):

_____

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_____

Additional Comments (if applicable):

_____

_____

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: _____

CAREGIVER SUPPORTS :

☐ Has Caregiver Support ☐ Is a Caregiver ☐ Insufficient Caregiver Support

Full Name: _____ Relationship: _____

Phone #: _____ Email: _____

EMERGENCY CONTACT:

Full Name: _____ Relationship: _____

Phone #: _____ Email: _____