



Cambridge Community Outreach Group

A Service of Kings Regional Rehabilitation Centre

REFERRAL FORM

Instructions:

- If a specific client is being referred, please complete SECTION A.
- If an agency is completing the referral for identified staff development needs, please complete SECTION B.
- The completed referral form and signed Authorization for Cambridge Community Outreach Group Consultation and Release of Information Form as well as additional requested documentation (*for specific client referrals only*) must be mailed or faxed to CCOG Coordinator:

Wendy Hayden, Coordinator
 Cambridge Community Outreach Group
 Kings Regional Rehabilitation Centre
 1349 County Home Road
 PO Box 128 Waterville
 Nova Scotia B0P 1V0

Fax: (902) 538-1294

SECTION A: CLIENT REFERRAL (complete **only** if specific client being referred)

i) Identifying and Contact Information:

Client Name: Last	First	Middle Initial
Preferred Name (if different from above):		
Date of Birth (M/D/Y):		
Name and Address of Current Place of Residence:		
Telephone Number:		
Length of Time at Current Residence:		
Referring Agency/Person:		
Telephone Number of Referring Agency/Person:		
Primary Contact Person:		
DCS Care Coordinator:		
Telephone Number:		Fax Number:

Cambridge Community Outreach Group Referral Form (continued)

Who is aware of this referral? Client____ Family____ Physician____
DCS Care Coordinator____
Other (specify)_____

Please describe the client's understanding of the reason for the referral:

Has client/guardian signed "Authorization for Cambridge Community Outreach Consultation and Release of Information Form"? Yes_____ No_____

Please attach a copy of the signed "Authorization for Cambridge Community Outreach Consultation and Release of Information Form to this referral form.

ii) Reason for Referral

Referral (Details/History of current concern/Duration of concern):

Has this person received interventions for this before? Yes_____ No_____
If yes, please briefly describe past interventions: _____

Desired outcome of referral:

Most recent assessments (attach if available) related to reason for referral (e.g. psychology, physiotherapy, medical, dietary, speech pathology). Please indicate date, nature of assessment, findings and recommendations if not attached.

Cambridge Community Outreach Group Referral Form (continued)

iii) Additional Client Information

All Diagnoses: _____

Name of Physician: _____ Name of Psychiatrist: _____

Medications: Please fax Medication Administration Record or comparable document with referral form (to include name of medication and dose)

SAFETY CONCERNS: YES (*check all that apply*) NO

<input type="checkbox"/> Choking	<input type="checkbox"/> Falls	<input type="checkbox"/> Allergies	<input type="checkbox"/> Sensory Sensitivities	<input type="checkbox"/> Aggression
<input type="checkbox"/> Seizures	<input type="checkbox"/> Pica	<input type="checkbox"/> Elopement	<input type="checkbox"/> MRSA (positive)	<input type="checkbox"/> Allegations
<input type="checkbox"/> Self-harm	<input type="checkbox"/> Suicidality	<input type="checkbox"/> Other: _____		

If you have answered yes to safety concerns, please provide additional information: _____

<p>COMMUNICATION: (Is this client able to express needs and wants) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If yes, how?</p> <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Verbal</td> <td><input type="checkbox"/> Gestures</td> </tr> <tr> <td><input type="checkbox"/> Vocalizations</td> <td><input type="checkbox"/> Sign Language</td> </tr> <tr> <td><input type="checkbox"/> Pictures</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Verbal	<input type="checkbox"/> Gestures	<input type="checkbox"/> Vocalizations	<input type="checkbox"/> Sign Language	<input type="checkbox"/> Pictures		<input type="checkbox"/> Other: _____		<p>VISION: <input type="checkbox"/> Good <input type="checkbox"/> Impaired Comment: _____</p> <p>HEARING: <input type="checkbox"/> Good <input type="checkbox"/> Impaired Comment: _____</p> <p>TEETH: <input type="checkbox"/> Own Teeth <input type="checkbox"/> Dentures <input type="checkbox"/> No Teeth Comment: _____</p>
<input type="checkbox"/> Verbal	<input type="checkbox"/> Gestures								
<input type="checkbox"/> Vocalizations	<input type="checkbox"/> Sign Language								
<input type="checkbox"/> Pictures									
<input type="checkbox"/> Other: _____									

MOBILITY: (check all that apply)	Yes	No	If Yes - Independent	If Yes - With Assistance
Walks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking Aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uses Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moved with Lift	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TOILETING: Independent With Assistance Incontinent

Does client need staff present for an appointment? Yes_____ No_____

Additional Comments: _____

Name of Person completing Referral Form:

 (Name - please print)

 (Signature)

 (Date)

Cambridge Community Outreach Group Referral Form (continued)

SECTION B: AGENCY REFERRAL (complete **only** if agency requesting professional development support)

i) Identifying and Contact Information

Name of Agency:
Address:
Primary Contact Person:
Telephone Number:
Fax Number:

ii) Reason for Referral

Referral (Details/History of current concern/Duration of concern):

Desired outcome of referral:

Other information/comments:

Name of Person Completing Referral Form:

(Name - please print)

(Signature)

(Date)

Cambridge Community Outreach Group Referral Form (continued)

Referral Checklist

Have you....

- Completed all information required in Section A (Specific Client Referral) or Section B (Agency Referral)
- Included the signed Authorization for Cambridge Community Outreach Group Consultation and Release of Information Form if completing Section A
- Included MAR or comparable document if completing Section A
- Included relevant reports if completing Section A
- Signed and dated the referral

Mail or fax to CCOG Coordinator:

Wendy Hayden, Coordinator

Cambridge Community Outreach Group
Kings Regional Rehabilitation Centre
1349 County Home Road
PO Box 128 Waterville
Nova Scotia B0P 1V0

Fax: (902) 538-1294

(For Cambridge Community Outreach Group Use Only)

DATE REFERRAL RECEIVED: _____

DATE REFERRAL REVIEWED BY CCOG REFERRAL SCREENING COMMITTEE:

RESPONSE TO REFERRAL:

ADDITIONAL REPORT(S) TO FOLLOW: YES NO

If yes, specify:

INTERVENTION ONGOING:

INTERVENTION COMPLETE:

Date: _____ **Signature:** _____

CLINICIAN/CONSULTANT REPORT(S) SUBMITTED: **SENT:**