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:

Jacquelyn Levy, 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:

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

☐ Choking	Falls	Allergies	Sensory Sensitivities	Aggression
☐ Seizures	Pica	Elopement	MRSA (positive)	Allegations
☐ Self-harm	☐ Suicidality	☐ Other: _____		

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

_____

_____

COMMUNICATION: (Is this client able to express needs and wants) ☐ YES ☐ NO

If yes, how?

☐ Verbal ☐ Gestures
☐ Vocalizations Sign Language
☐ Pictures
☐ Other: _____

VISION: ☐ Good ☐ Impaired
Comment: _____

HEARING: ☐ Good ☐ Impaired
Comment: _____

TEETH: Own Teeth ☐ Dentures ☐ No Teeth
Comment: _____

MOBILITY: (check all that apply)	**Yes**	**No**	**If Yes - Independent**	**If Yes - With Assistance**
Walks	☐	☐	☐	☐
Walking Aid	☐	☐	☐	☐
Uses Wheelchair	☐	☐	☐	☐
Transfers	☐	☐	☐	☐
Moved with Lift	☐	☐		

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)

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)

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:

Jacquelyn, 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:** ☐