VON SMILE Program Referral Form

SMILE Fax *(for referrals & assessments only)*: **1-877-300-4370**

Client Information

First Name:	**Last Name:**	**First Language (spoken or preferred)**
Address:	**Apt:**	**City:**
Total Income:	**Postal Code:**	**Phone Number:**
Age: *(senior must be 65 years or older)*	**DOB:***(mm/dd/yyyy)*	**Sex:** ☐ Female ☐ Male

InterRAI CHA/InterRAI-HC Completed: ☐ Yes ☐ No ☐ Unknown **OHIP #:** **Date Completed:**

Emergency Contact

Name:	Phone:	Relationship:	Caregiver:	Call Emergency Contact for DOE/Admission:

Additional Information

****Health Information/Medical Diagnosis:**

What services does client currently receive? (Including family, friends and private pay)

What is the reason for the referral to SMILE?

The senior has the following unmet needs *(senior must have unmet needs)*:

☐ Meal Support ☐ Shopping ☐ Housekeeping ☐ Laundry ☐ Outdoor Chores ☐ Transportation ☐ Foot Care ☐ Respite ☐ Security Checks

Referral Information

Referral Source:

☐ Paramedicine
☐ Nurse Practitioners
☐ Physician
☐ Other - Specify
☐ Family Health Team
☐ Community Health
☐ HCCSS

Additional Information:

Person completing this form: _____
(Print Name)

Date: _____ **Phone Number:** _____

****Ensure Health Information/Medical Diagnosis section is filled out before summitting this form to SMILE**

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