Hospice North Hastings
CARING WHEN THERE IS NO CURING

REFERRAL FORM - MEDICAL ELIGIBILITY DETERMINATION

Please complete the form and fax 613-332-8017. Prior to sending the form call 613-332-8014 to inform of request.

Program Requested:
☐ **Residential Hospice** ☐ **Home Visiting Program**

Client Information					
Name of Client:		**Birth Date:**		**Referral to HCCSS:** NO	
Health Card Number:		**HCCSS Coordinator(if applicable):**		**Date of Referral:**	
Client's Current Location - Where the Assessment will Occur					
Type of Location:	Home	Hospital	Nursing Home	Res Care	Other
Street Address:		**Town:**		**Phone:**	
Contact Name for Facility if applicable:				**Facility Contact's Phone:**	
Is the Client aware of this referral?					
Name of Person Sending this Referral:					
Doctor's Office Information/Diagnosis Information					
Name of Primary Care Dr:			**Practice Address:**		
Dr's Phone:			**Dr's Fax:**		
Diagnosis:		**Prognosis:**		**PPS:**	
Mobility/Hearing/Pain/Behaviors/etc.:					
Current Support/MAID					
Family Involvement?		**Home Care Agency:**		**MAID Discussed:**	
Person to Contact on Behalf of the Client					
Primary Contact Name:		**Phone:**		**Secondary Phone:**	
Contact's Address:					
Relationship to Client:		**Other:**			
Does Client have a Medical POA? YES / NO / UNKOWN		**Name:**		**Phone:**	
Referral Comment Information					

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