Capital Health
Integrated Continuing Care

Continuing Care Referral FAX TO (902) 455-3809

Client Information – Section A

Health Card#	___/___/___/___/___/___/___/___/___/___/___/	Birth date	___/___/___/___/ YYYY	___/___/ MM	___/___/ DD
Client Name	Last Name	First Name		Initial	
Civic Address	Street/Apt	City	Postal Code		
Service Address (if different from Civic Address)	☐ n/a Street/Apt	City	Postal Code		
Client Telephone	Home	Cell	Other		
Contact Person	Last	First Name	Relationship		
Contact Telephone	Home	Work			

Client consent – Section B

Is client or SDM aware of referral to Continuing Care & sharing personal health information with agencies providing service?
□ Yes □ No If not, why?

Referral Information – Section C

Referral Source		Referral Date (YYYY, MM, DD)	
Referral Contact	Telephone	Cell	Pager
Family Physician	Last Name	First Name	Telephone
Estimated Date of Hospital Discharge		☐ D/C Today	

Reason for Referral – Section D

Nursing: ☐ Wound care ☐ IV Therapy ☐ Injections ☐ Medication Management (Physician Order / signed med list required)
Other: ☐ Home Support ☐ Palliative Care ☐ Oxygen* ☐ Blood Transfusion*
☐ Adult Protection

*Home Oxygen and Blood Transfusion require a specific order form, not the Physician Order

Health Problems/Diagnosis:

Community Pharmacy:

Pre-visit risk identification / Worker Safety – Section E

To your knowledge, is there any reason a home visit to this client may pose a risk to staff?	☐ Yes ☐ No
Do you have any pets? If so, client please secure pet in another room when staff visit.	☐ Yes ☐ No
Does anyone else live in your home, and will they be present if a care provider is there? If so, when and who?	☐ Yes ☐ No
Do you have any guns or other weapons? If so, do you keep them locked?	☐ Yes ☐ No
Do you or others in your home smoke? If so, please refrain from smoking during staff visits.	☐ Yes ☐ No

Completed by : **Date**