SAFETY AT HOME PROGRAM
REFERRAL FORM

Please FAX to the appropriate Safety at Home Program:

Hamilton	**905-522-5579**	**(phone 905-522-6887 Ext 2237)**
Niagara	**905-682-2957**	**(phone 905-682-3800 Ext 28)**
Haldimand-Norfolk	**519-426-4108**	**(phone 519-426-6060 Ext 104)**
Brant	**519-759-3924**	**(phone 519-759-7750 Ext 233)**

Client's Last Name: _____First Name:_____

Spouse/Partner Name**:** _____

Address:_____

City: _____ **Postal Code**: _____

Telephone #: _____ **Cell:** _____

Date of Birth (DOB): _____ Spouses DOB: _____

Ont. HCN: _____Spouses HCN: _____

Family Contact: _____ ___**Relationship:** _____

Telephone# : (h) _____ ____**(w)** _____

__ Phone family for consent or __ Client can consent

Medical Conditions/Health Risks :_____

_____

History of Falls: Yes ___ No ___ Not sure ___ Physician: _____

Reason for Referral: _____

Referred by : _____ **Position :** _____

Organization: _____ **_ Phone#:**_____ **Ext** _____

Referral Consent Obtained: ___ Date: _____

Supported by:

Ontario
Hamilton Niagara Haldimand Brant Local Health Integration Network
Réseau local d'intégration des services de santé de Hamilton Niagara Haldimand Brant