A close up of a logo

Description generated with very high confidence

Campbell River Hospice Society 440 Evergreen Road Campbell River, BC V9W 0C7

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www.crhospice.ca

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Client Intake / Referral

|  |  |
| --- | --- |
| Date: | Completed by: |

|  |  |
| --- | --- |
| Client Name:  (First) (Last) | |
| Address:  (City) (Prov) (Postal Code) | |
| Phone: (h) (c) (w)    Message  Y  N Message  Y  N Message  Y  N  Email: | |
| Date of Birth: Age:  (D-M-Y) | Gender: M  F  Other |
| Referred by:  Self  Doctor  Hospital  Friend  Family Member  HCC  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Services required for:**  **Grieving**  **Facing End of Life** | |
| Have you been a client of Hospice before?  Y  N If yes, give details. | |
| **Client has given permission / is aware of referral?**  **Y**  **N** | |
| Name of Parent / Guardian (if under 18 years of age):  Is MCFD involved?  Y  N | |
| Emergency Contact: | Relationship: |
| Address:  (City) (Prov.) | |
| Phone: | |

Client Information

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| Support Network – Personal  Support Services - Professional |
| Spiritual Practice |
| EFAP Resources available?  No  Yes Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Mobility Issue  Yes  No Other mobility considerations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Location services requested:  Home  Hospice Care Centre  Hospital Room # \_\_\_\_\_\_\_\_  Yucalta Room #\_\_\_\_\_\_\_\_\_ |
| What services interest the client?  Counselling  Art Therapy  Grief Walking Group  Grief Support Group    Companioning  Lending Library  Hospital/Yucalta Visits  Spiritual Care  Reiki  Reflexology  Therapeutic Touch  Advance Care Planning |

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| Notes: |
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