

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

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| Date: | Completed by: |

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| 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 – PersonalSupport 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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