Campbell River Hospice Society
Referral Form

This form can be completed as a self-referral, health-care professional, family member or other. Once you submit this form, it will go directly to our Client Coordinator who will follow-up with the client. Please email: karen@crhospice.ca or fax: 250 286 1195

Client Information

First Name:_____ Last Name:_____

Email Address:_____

Home Phone:_____ Can we leave a message. Y or N

Cell Phone:_____ Can we leave a message. Y or N

Date of Birth:_____

Type of Service Needed

- End-of-Life support
- Grief Support

If this person is palliative please provide the location and room number:_____
_____

Referrals Information

Tell us who is completing this referral form

- Doctor
- Nurse
- Caregiver
- Family Member
- Self-Referral
- VIHA Palliative Team
- Yucalta Health Team
- Mental Health
- MCFD
- Long-term Living Facility
- Other

If Other please explain: _____

Referrals First Name:_____ Last Name:_____

Email Address:_____

Office Phone:_____ Cell Phone: _____

Is the client aware of this Referral? Y N

Who should we contact regarding this referral?

- Client
- Person making this referral

Other Comments

_____
_____
_____
_____
_____

- I declare that the info I've provided is accurate & complete

Date:_____

Signature:_____

Thank you