Hospice West Parry Sound
Client Referral Form

Fill in the following client information, print form and fax to 705-996-1133
(to connect with a staff member, phone: (705) 746-4540 ext.1416 or email: hospice@wpshc.com)

Service(s) requested:	☐ In-home visiting volunteer	☐ grief/ bereavement support
Permission given by client for Hospice WPS to contact them?	**☐ Yes**	**☐ No**

Client Name			Date of Birth (MM/DD/YYYY)
Address			
City			Postal Code
Phone	Home	Cell	Email
Name of Caregiver			Relationship
Address *same as above* ☐		**or**	
Phone	Home	Cell	Email
Name of Substitute Decision Maker		*same as caregiver* ☐	
Phone	Home	Cell	Email

Medical Information

Diagnosis:
History (other relevant information):
Medications:
Client/Caregiver stressors/concerns:

For Home Visiting Volunteer Support
(home, residence, long term care, hospital)

Useful information:

For Grief and Bereavement Support

Name of deceased/dying	Relationship
Date of death	
Check off all applicable: ☐ grief ☐ anxiety ☐ depression ☐ failure to cope	
Other information:	

Referral Source

Name of referral source/organization	Phone
☐ Doctor ☐ NP ☐ OH-CareCoor ☐ Self ☐ Family ☐ Friend ☐ Other	
Name of Primary Doctor/Nurse Practitioner	Phone

Referral Completed by: _____(signature) Date: _____

_____(print)

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Website: www.parrysoundhospice.ca