A Port in the Storm Client Referral Form

This is a residential facility. No medical or nursing staff are available on site.

PLEASE ENSURE REFERRAL FORM IS COMPLETELY FILLED OUT

Guest Information

Name:_________________________Will the client be staying in our facility____Yes______No
Nature of illness:____
Complete address:____City/Town_____________
Province:______________________Postal Code:______________________
Home #:_______________________Cell#:__________________________
Email address: ____
Returning client? ___Yes____No
Does the client have an E.R.I.K.? ___Yes___No
*If yes, please ensure it accompanies the client during their stay.

Caregiver emergency contact information

Caregiver name:____________________________Relationship to client___________________
Home #:_________________Cell#:______________Email address:___________________________
Email:____
Emergency contact person:__________________Relationship to client____________________
Home#__________________Cell#:______________Email address:___________________________

Living Arrangements

Expected length of stay______________# of occupants staying in our facility_______________
Will the client have an escort____Yes_____No
Does the client require Home Care services ____Yes____No
Have prior arrangements been made for this service_____Yes____No
Please specify____

Anticipated check-in date:_________________

Anticipated check-out date:__________________

Is a parking space required?_____Yes_____No
*Arrangements will be made upon arrival.

Referral Information

*Please check one

Doctor_____Nurse_____Patient Navigator____Social Worker___Other_______(Please indicate)
Name of professional and title:____
Phone#:_________________Email:____
Will you continue to follow this client during their stay in Winnipeg ____Yes____No
If not, who is the receiving health care provider____

Date_____________________ Signature of Referring Agent_____________________________

Method of Payment

*Please check one

Cheque______Credit Card (Visa or MC only)______Debit______
*Cash will not be accepted

Self Paid _____ Covered by Insurance______

Will this be billed to a Government Agency? Yes _______ No ________
Name of the Government Agency for Third Party Billing:

____

Third party billing must be pre-approved in advance by the Third Party Agency

Disclosure Statement

I_________________(please print) authorize my referring agent to disclose of this medical information to A Port in the Storm Inc. I understand that this information will be kept confidential under A Port in the Storm's confidentiality policy and will be used for the sole purpose to, a) prioritize referrals to A Port in the Storm facility; and/or b) ensure client's needs regarding required services and equipment are identified. I understand that no personal identifying information will be used in any other way.

Date_____________________ Signature____

Please fax this document to: 204-594-6435 or email: admin@aportinthestorm.ca