Hospice Dufferin Referral Form

Call 519 942-3313 ext 2 or LVanEindhoven@hospicedufferin.com

☐ Palliative Client ☐ Caregiver Only ☐ Palliative Client and Family ☐ Bereavement

Palliative Client Referral		Name	
Diagnosis		When Diagnosed	
PPS %		End of Life issues have been discussed with patient	

Lives alone ☐ Married or common law ☐ Widowed ☐ Home and Community Support Coordinator

☐ Check if the caregiver below is the person to schedule a home visit

Caregiver Referral		Name of Caregiver:	
Others in Home		End of Life issues have been discussed with caregiver	

Bereavement Referral		Name	
Deceased Name		Relationship to Referral	
Date of Death		Additional information (if applicable): (mental health diagnosis or unusual death circumstances)	

Date of Birth	
Address	
Phone Number	
Preferred Language	
Email	

Reason for Referral	
	Social Worker
	Bereavement support
	Social and/or Wellness Programs
	Volunteer Support in home/hospital/ LTC
	Other:

Referral made by	
Name:	Phone Number:
Email:	Organization: