Social Prescribing Referral Form
Edmonton Seniors 55+

Send completed form to: aic@mysage.ca
or via fax to: 780-426-5175 Attention: Social Prescribing
Phone Number: 780-809-9411

CLIENT INFORMATION:

☐ Urgent Referral

Full Name: _____ Phone #: _____

Address: _____

City: _____Postal Code: _____

Primary Contact if different than the Client:_____

Best time of day to call: _____

Can a message be left? ☐Yes ☐No ☐Unsure

Building Type: ☐ Apartment ☐ House ☐ Other: _____

Gender: ☐ Male ☐ Female ☐ Other Date of Birth: _____

Primary Language: _____ Additional Languages: _____

Primary Source of Income (If known): _____

Living arrangements: ☐ Alone ☐ Spouse ☐ Family ☐ Other: _____

Client is receiving supports through Meals on Wheels:

☐ Yes ☐ No ☐ Unsure

Client Equity Information: Select any/ all that may apply.

☐ First Nations/ Metis/ Inuit ☐ Member of Visible Minority (Non-Indigenous)
☐ Ethnocultural Minority ☐ Person with Disabilities
☐ Immigrant ☐ Newcomer ☐ _____

CLIENT HOSPITALIZATION DISCHARGE DATE (if applicable): _____

REASON FOR REFERRAL:

Please select all that might apply

☐ Navigation of Community Supports and Services
☐ Application for Financial benefits
☐ Meal Assistance/ Food Security
☐ Housekeeping
☐ Grocery shopping
☐ Assisted Transportation
☐ Socialization
☐ Housing
☐ Legal Assistance
☐ Elder Abuse
☐ Snow Shoveling/ Yard Maintenance
☐ Recreation/ Leisure
☐ Other _____

SPECIAL CONSIDERATIONS:

Please specify any circumstances for consideration:

- ☐ Cognitive or Memory Challenges
- ☐ Mental Health Issues
- ☐ Physical Mobility
- ☐ Clutter/ Hoarding
- ☐ Hearing Impairment
- ☐ Visual Impairment
- ☐ Other_____
- ☐ Grief and Loss
- ☐ Diverse Cultural Need
- ☐ Literacy Support
- ☐ Isolation
- ☐ Caregiver Concerns
- ☐ Health Challenges/ Barriers

HOME CARE CASE MANAGER (if Applicable):

Full Name: _____Phone #: _____

Fax #: _____Email: _____

Services Provided: _____

ADDITIONAL SUPPORTS (CAREGIVER, FAMILY, OTHER AGENCYS INVOLVED):

Contact #1 - ☐ Caregiver ☐ Family ☐ Agency ☐ Other: _____

Full Name: _____Relationship: _____

Phone #: _____ Email: _____

Contact #2 - ☐ Caregiver ☐ Family ☐ Agency ☐ Other: _____

Full Name: _____Relationship: _____

Phone #: _____ Email: _____

REFERRAL MADE BY:

☐ HomeCare/ Home Living ☐ Family Doctor ☐ Hospital

☐ Primary Care Network ☐ Community Agency ☐ Other _____

Date: _____ Dept: _____

Full Name: _____Phone #: _____

Fax #: _____Email: _____

*PLEASE ENSURE CONSENT TO DISCLOSE HEALTH INFORMATION IS GIVEN PRIOR TO SUBMISSION

Sage Seniors Association

JFS EDMONTON

EDMONTON SENIORS COORDINATING COUNCIL

MCHB Multicultural Health Brokers Cooperative

DRIVE HAPPINESS