BELLWOODS
INNOVATING INDEPENDENCE

Community Connect (CC) and MILE Referral Form

Application to: ☐ 6 month CC program ☐ MILE Community

Referral Source: _____ Date: _____ (dd/mm/yy)

Client Name: _____ (First, Last) Date of Birth: _____ (dd/mm/yy)

Health Card #: _____ Phone #: _____

Address: _____ (street # and name, apt #, city, postal code, hospital room/bed # if applicable)

Alternate Contact: _____ (First, Last) Phone #: _____

Relationship: _____ ☐ SDM ☐ POA property ☐ POA personal care

Admission Date: _____ (dd/mm/yy) Discharge Date: _____ (dd/mm/yy)

Primary Diagnosis: _____ Date of Onset: _____

Secondary Health Issues/Communicable Diseases: _____

_____

Reason for Referral: _____

_____

Completed by:

Name: _____ (First, Last) Signature: _____

Title: _____ Phone #: _____

Applicant Signature: _____ Date: _____ (dd/mm/yy)