Social Prescribing Referral Form
Age Friendly Cold Lake Society

Send completed form to: director@agefriendlycoldlake.ca
or via fax to 587-851-3468 / Attention: Social Prescribing

REFERRAL MADE BY (PLEASE ENSURE CONSENT TO DISCLOSE INFORMATION IS GIVEN BEFORE SUBMISSION)

☐Homecare/Home Living ☐Family Doctor ☐Hospital
☐Primary Care Network ☐Community Agency ☐Other_____
Date:_____ Name:_____Phone #:_____
Fax #:_____ Email:_____

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

The client is receiving support through Meals on Wheels:
☐Yes ☐No ☐Unsure

Client Equity Information: Select any/all that may apply.
☐First Nations/Metis/Inuit ☐Members of Visible Minority (Non-Indigenous)
☐Ethnocultural Minority ☐Person with Disabilities
☐Immigrant ☐Newcomer ☐Other:_____

CLIENT HOSPITALIZATION DISCHARGE DATE (if applicable):_____

_____

REASON FOR REFERRAL:

☐Housekeeping ☐Caregiver Stress

☐Meal Assistance/Food Security ☐Appointment Assistance

☐Grocery Shopping ☐Grief Support

☐Transportation ☐End of Life Doula

☐Socialization ☐Minor Home Maintenance

☐Elder Abuse ☐Short-term caregiver respite

☐Medical equipment loans ☐SLUMS Cognitive Testing

☐Advocacy ☐Men's Shed

☐Seniors Resource Library ☐Dementia Resource Kits

☐Other:_____

SPECIAL CONSIDERATIONS:

☐Cognitive or Memory Challenges ☐Grief and Loss Support

☐Mental Health Issues ☐Diverse Cultural Needs

☐Physical Mobility ☐Literacy Support

☐Clutter/Hoarding ☐Isolation

☐Hearing Impairment ☐Caregiver Concerns

☐Visual Impairment ☐Health Challenges/Barriers

☐Pets in the Home ☐Other:_____

HOME CARE CASE MANAGER (if applicable):

Full Name:_____ Phone #:_____

Fax #:_____ Email:_____

Services Provided:_____

ADDITIONAL SUPPORTS REQUIRED (CAREGIVER, FAMILY, OTHER AGENCIES INVOLVED:)

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

Full Name:_____ Relationship_____

Email:_____ Phone #:_____

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

Full Name:_____ Relationship_____

Email:_____ Phone #:_____

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Alberta Health Services