



NEAR NORTH PALLIATIVE CARE NETWORK

347 Sherbrooke Street, Suite 302, North Bay, Ontario, P1B 2C1
Phone: (705) 497-9239 1-800-287-9441 Fax: (705) 497-1039
Mattawa: 705-744-3771 Sturgeon-Falls: 705-753-5771
E-mail: office@nnpccn.com Website: www.nnpccn.com

CLIENT SERVICES REFERRAL FORM

Date:
(MM/DD/YYYY)

PART I. GENERAL INFORMATION:

Client's Last Name: Client's First Name:
Phone #: Date of Birth (MM/DD/YYYY):
Mailing Address:
City: Province: Postal Code:
Company: Company Phone #:

<p>Are you the client? YES <input type="checkbox"/> NO <input type="checkbox"/> If NO, specify your name, phone number and relationship to the client you are referring to us: Name: Phone number: Company: Relationship to the client:</p>	<p>Is the client* currently being seen by a health care professional? YES <input type="checkbox"/> NO <input type="checkbox"/> (* The client = you or the client you represent) If YES, specify the name and area of specialization of the health care professional:</p>
<p>What are you looking for?</p> <p>Telephone Support <input type="checkbox"/> Palliative Care Services <input type="checkbox"/> Respite Services <input type="checkbox"/> Bereavement Individual Session <input type="checkbox"/> Bereavement Group Session <input type="checkbox"/> Information <input type="checkbox"/> Medical Loan Cupboard <input type="checkbox"/> Lending Library <input type="checkbox"/> Education and Training <input type="checkbox"/> Other (specify): <input type="checkbox"/></p> <p>Best time to contact you: Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/></p>	<p>Health care services being provided to you/to the client:</p> <p>Medical Care <input type="checkbox"/> Social Worker Support <input type="checkbox"/> Palliative Care Services <input type="checkbox"/> Respite Services <input type="checkbox"/> Home Support Services <input type="checkbox"/> Bereavement Individual Sessions <input type="checkbox"/> Grief Information Evenings <input type="checkbox"/> Grief Self-Help Support Group <input type="checkbox"/> Support Group <input type="checkbox"/> Still on waiting list <input type="checkbox"/> Other (specify): <input type="checkbox"/></p>

How did you hear about our service? Brochure Family Friend Website

Other (specify):

Confidentiality. The information contained in this communication is private and confidential, intended only for the named recipient(s). If received in error, please notify the sender by telephone immediately and keep the information in a secure manner until further direction is given by the sender. Do not copy the information or disclose it to any other person.



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PART II. If you are looking specifically for Bereavement and Grief Services please fill the information below:

Name of the Deceased:

Date of Death (MM/DD/YYYY):

1. Your relationship to the Deceased:

- Wife
Husband
Daughter
Son
Sister
Brother
Mother
Father
Friend
Other Specify:

2. Nature of Death:

Unexpected Expected

Illness/Long Term Specify:

Suicide Specify:

Crime Specify:

Accident (vehicle, work related, fire, etc) Specify:

Child Death Specify:

Stillbirth

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NNPCN Website Client Services Referral Form (print format)