

Nav-CARE Referral Form

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral Information**

Referral Source:

* **Physician**
* **Healthcare Professional**
* **Community Agency**
* **Family member**
* **Friend**

**Other** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source has received verbal consent from client to forward name and below criteria to Nav-CARE Volunteer Coordinator: Yes\_\_\_\_ No\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_

 Client Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nav-CARE Criteria**

Serious Illness: Yes \_\_\_\_No \_\_\_\_

Experiencing 1-2 Quality of Life Indicators: Yes\_\_\_\_ No\_\_\_\_

 (Check boxes that apply)

* Loneliness or social isolation
* Recent loss or multiple losses
* Mobility or sensory challenges
* Increased disengagement
* Coping with transitions and multiple decisions
* Difficulty finding or accessing information or resources

Living Arrangements (check box that applies)

* Home
* Supportive housing
* Assisted living

Contact:

Suzanne Lehbauer

Castlegar Hospice Society

709 10th Street

Castlegar V1N2H7

250-304-1266

Suzanne.lehbauer@interiorhealth.ca