Circle of Care Referral Form

780-897-0066
admin@abnwpalliative.ca
www.abnwpalliative.ca

Referral Criteria

Individuals can be of any age, but must have a life limiting illness at any stage.

Circle of Care Brief Description

Alberta Northwest Palliative Care Society's Circle of Care Program is available at every stage and any age of a progressive life limiting-illness. We believe palliative care is not just about end of life,but about living well with support, dignity, and connection. Circle of Care is a community-based, in-home palliative support program designed to help individuals remain in the comfort of their own residence. Our specially trained volunteers are matched to you (or your family member) for non-medical companionship (friendly visiting), advance care planning and/or navigation assistance. Scheduled visits will be coordinated between the recipient and the volunteer and will occur in the recipient's place of residence. There is no cost to the individual (or family) for the Circle of Care Program, or other Alberta Northwest Palliative Care programs.

Referral Information

Self Referral

Name _____

Phone _____ Email _____

Number _____

Were you referred to our program? ☐ Yes ☐ No

Health Care Team Referral

Referring Professional Name _____

Role / Title _____

Organization / Clinic Name _____

Address: _____

Email: _____

Phone _____

Family Member Referral

Relationship to Recipient: _____

Address: _____

Email: _____

Phone _____

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Primary Contact (for schedualling and communication)

☐ Care Recipient

Primarty Contact Details (if not the care recipient) _____

Relationship _____ Email _____

Phone _____

Recipient Information

Gender ☐ Male ☐ Female ☐ Other Pronouns Used _____

First Name _____ Middle Name _____ Last Name _____

Date of Birth (M/D/Y) _____

Email Address _____ Municipality _____

Address _____

Postal Code _____ Cell Phone: _____ Home Phone: _____

Reason For Referral

Services Required

☐ Companionship

☐ Advance Care Planning

☐ Navgiation Assistance to Other Support Systems

Referral / Recipient Awareness

Does the recipient know they have been referred for Circle of Care ☐ Yes ☐ No

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Recipient Health Info:

Mobility:

Cognition:

Other Agencies Being Used: _____

Special Considerations our Volunteer should be aware of: (ie: language preferences, cultural &/or religious needs, special interests):

Confirmed Diagnosis with diagnosis date if possible:

Any additional information you would like to provide:

To avoid referral delays, please ensure ALL referral and patient information is provided. Referring provider will be notified if referral is declined.

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