lifemark Seniors Wellness

For Inquiries Please Call 1.877.696.1620

Community Step Up Referral Form

REFFERAL INFORMATION	
Referral Date:	**Organization Name:**
Contact Name:	**Contact Number:**
Email:	**Client/SDM Approved Referral:** Y ☐ N ☐
CLIENT INFORMATION	
Client Name:	**Gender:** Male ☐ Female ☐
DOB: (d/m/y)	**HC#**
Contact #:	**Email:**
Street Address:	**City:**
Postal Code:	**Language:**
IF REQUIRED: SUBSTITUTE DECISION MAKER INFORMATION	
SDM Name:	**Day Time #:**
Evening #:	**Email:**
Street Address:	**City:**
Postal Code:	**Preferred Language:**
MEDICAL INFORMATION	
Primary Care Physician Name:	**Physician Fax #:**

Overall Health Concerns:

☐ Acute Injury/event (sprain, fracture, cardiac, neuro)
☐ Coughing while eating or taking longer to eat meals
☐ Making modification to their foods or avoiding certain foods
☐ Gradual or sudden change in their communication
☐ Difficulty understanding what the client is saying (not related to ESL)
☐ Post operative
☐ Needs Support with ADLs
☐ Unsteady on Feet
☐ Post Fall
☐ History of acid reflux
☐ Difficulty finding their words
☐ Taking longer to eat meals
☐ Mobility/Ambulation

Chronic Conditions:

☐ Alzheimer's/Dementia
☐ Asthma
☐ Cardiac
☐ Diabetes
☐ Stroke
☐ Other_____
☐ Arthritis
☐ Cancer
☐ COPD
☐ Neurological (ALS, MS, Parkinson's)
☐ Shortness of Breath

Functional Concerns:

☐ Balance ☐ Strength ☐ Range of Motion ☐ Gait ☐ Swallowing

Other Concerns:

Fax Completed Form to 1.855.412.6627