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:	**Preferred 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:

- ☐ Balance
- ☐ Strength
- ☐ Range of Motion
- ☐ Gait/Ambulation
- ☐ Acute Injury (sprain, fracture, cardiac, neuro) (not related to ESL)
- ☐ High risk for falls/post fall
- ☐ Pain
- ☐ Needs support with ADLS
- ☐ Fine motor skills
- ☐ Home Safety
- ☐ Coughing while eating
- ☐ Taking longer to eat meals
- ☐ Making modifications to their foods
- ☐ Gradual or sudden change to communication
- ☐ Difficulty understanding what the client is saying (not related to ESL)
- ☐ Difficulty finding their words

Chronic Conditions:

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

Other Concerns:

Fax Completed Form to 1.855.412.6627