Elder Abuse Referral Form

Please complete and send by fax (613) 932-0998 or by email tmayich@carefor.ca

Referral Information

Date: _____ Completed By: _____

Referral Name: _____ Agency: _____

Referral Phone: _____ Client aware of referral: Yes ☐ No ☐

Client Information

Client Name: _____ D.O.B: _____

Address: _____

Client Phone: _____ Health Card: _____

Age: 60-69 ☐ 70-79 ☐ 80-89 ☐ 90-99 ☐ 100 + ☐ Gender: Female ☐ Male ☐

Cornwall ☐ Akwesasne ☐ Stormont ☐ Prescott-Russell ☐ Dundas ☐ Glengarry ☐

Living Arrangements

Owns Home ☐ Lives alone ☐ Partner/Spouse ☐ Resides Family ☐ Apartment ☐

Retirement Home ☐ LTC ☐ Hospital ☐ Crisis Bed ☐ Other:_____

Agency Support Services Involved

LHIN ☐ CMHA ☐ Addictions ☐ Crisis Team ☐ Outreach ☐ ASAP ☐ Police ☐

ACTT ☐ Paramedics ☐ Geriatrics ☐ Police ☐ Hospital ☐ Other: _____

Carefor

ACCREDITED WITH EXEMPLARY STANDING
ACCREDITATION AGRÉMENT CANADA

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Type of Abuse

Physical ☐ Financial ☐ Sexual ☐ Psychological ☐ Neglect ☐ Other: _____

Alleged Perpetrator

Alleged Perpetrator: _____ Relation: _____

Address: _____ D.O.B _____

POA: _____ Family Contact: _____

Barriers to Community Services

Fear ☐ Income ☐ Transportation ☐ Refusal ☐ Family ☐ Trauma ☐ Capacity ☐

Addictions ☐ Finances ☐ Mental Health ☐ Language ☐ Other: _____

Client Needs

Assessment ☐ Addictions ☐ Mental Health ☐ Safety Plan ☐ Medical ☐ LHIN ☐

Housing ☐ Hoarding ☐ Isolated ☐ Capacity ☐ Legal ☐ Other: _____

Describe Concerns and Interventions

_____

_____

_____

Community Service Referrals Made

LHIN ☐ CMHA ☐ Addictions ☐ Mental health ☐ Capacity Assessor ☐ Geriatrics ☐

PCO ☐ ACTT ☐ Carefor ☐ OPGT ☐ Housing ☐ Legal ☐ Other:_____