North Okanagan HOSPICE SOCIETY

Nav-CARE
Making Connections, Making a Difference

Nav-CARE Referral Form

Date: _____

Referral Information

Referral Source: ☐ **Physician** ☐ **Family member** ☐ **Friend** ☐ **Healthcare Professional**
☐ **Community Agency** ☐ **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: _____ Client Phone Number: _____

Address: _____ City: _____

Postal code: _____

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
☐ Difficulty coping with transitions and multiple decisions
☐ Difficulty finding or accessing information or resources

Living Arrangements (check box that applies)
☐ In own Home
☐ Supportive housing
☐ Assisted living

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