NFLA SOCIAL PRESCRIBING PROGRAM REFERRAL FORM

Referral Date: _____

REFERRER Information/Physician Office (*Stamp or name, phone and/or fax)*:

Name/Title: _____

Phone/Fax: _____

Address: _____

Email: _____

Please select the kind of services you would like to refer this individual to. For criteria and more examples of non-clinical services that may benefit your patient, please review the Referral Guide on the reverse side. Please include as much patient information as possible, where available.

PATIENT/PARTICIPANT Information:

Name: _____

Phone: _____

Address: _____

Email: _____

DOB: _____ PHN: _____

Alternate Contact Name: _____

Relationship: _____ Phone: _____

- ☐ Social / Physical Activity
- ☐ Housing Support
- ☐ Nutrition/Food Programs
- ☐ Community Services
- ☐ Counselling Programs
- ☐ Other:

Current Services Involved

- ☐ Home Health
- ☐ Seniors Outpatient Clinic
- ☐ Mental Health
- ☐ Other Services
- ☐ Not Applicable

Additional participant information *(i.e. discharge date, hearing/visual loss, mobility restrictions, primary language, family contact information, safety concerns, substance use, etc.):*

☐ **Client has given consent to this referral**

FAX completed forms to: 250-753-0268

NANAIMO FAMILY LIFE ASSOCIATION

United Way British Columbia

Working with communities in BC's North, Interior, Lower Mainland, Central & Northern Vancouver Island

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REFERRAL GUIDE

Program Description

Guided by the Social Determinants of Health, the Social Prescribing program supports seniors to access community-based services to prevent or delay frailty by fostering resilience and social support using a comprehensive, strength-based approach. Health Care practitioners, physicians and other community members can refer an individual to a Community Connector, who will work with the individual to support their well-being.

Referral Criteria

Seniors who are experiencing one or more of the following:

- Social isolation
- Depression/anxiety
- Major life events such as loss of a spouse
- Living with chronic disease
- Physical inactivity
- Frailty or danger of frailty
- Poor nutrition and/or food insecurity concerns
- Poor health outcomes associated with social determinants of health (low income, Indigenous/Metis/Inuit, LGBTQA2S, history of Adverse Childhood Experience etc.)
- Frequent use of primary health care.

Examples of Non-clinical Community Support Services (Services may vary)

- **Social Programs**
  - Social groups and meals, community activities, coffee clubs, special events, volunteer programs, vocational opportunities, support groups and education sessions.
- **Physical Activity Programs**
  - Fitness classes, walking groups, chair yoga, lawn bowling, Aquafit, and sports.
- **Community Services**
  - Access to information and support for transportation, affordable housing or food/nutrition programs.
- **Counselling and Mental Wellness Programs**
  - Support groups, education sessions, one-to-one support.

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