

Referral Date: _____

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

Referrer Name/Position: _____
Referring Organization: _____
Direct phone: _____
Email: _____

PATIENT/PARTICIPANT Information:

Name: _____
Phone: _____
Address: _____
DOB: _____
Primary Language: _____
Alternate Contact Name: _____
Relationship: _____ Phone: _____
Lives Alone (Yes/No): _____

- ☐ Social Engagement
☐ Physical Activity
☐ Nutrition/Food Programs
☐ Community Services
☐ Caregiver Programs
☐ Other:

Current Services Involved

- ☐ Home Health
☐ Seniors Outpatient Clinic
☐ Mental Health
☐ Other Services

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

Referral Criteria:

- ☐ Participant has provided verbal consent prior to referral
☐ Willing and able to develop a wellness plan with Senior Community Connector
☐ Older adult age 65+ living in Langley
☐ Socially isolated or lives alone
☐ Low to moderate frailty
☐ Low to modest income
☐ Member of an underserved/equity-deserving group

FAX to: 604-532-1320

REFERRAL GUIDE

Program Description

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

To find this Referral form please visit: <https://lsrs.ca/community-services/>

To submit this Referral please Fax to 604-532-1320.

Referral Criteria

Seniors 65+ living in Langley who may be experiencing two or more of the following:

- Social isolation
- Depression/anxiety
- Major life events such as loss of a spouse
- Living with chronic disease or disability
- Physical inactivity or living with mobility challenges
- Mild to moderate frailty or danger of frailty
- Poor nutrition and/or food insecurity concerns
- Individuals experiencing health inequities related to social determinants of health (e.g., low income, Indigenous identity, 2SLGBTQIA+ identity, experiencing cultural or linguistic barriers)
- 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, 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, home maintenance, food/nutrition programs, information and resource referrals.
- **Caregiver Programs**
 - Support groups, education sessions, one-to-one support.

