



Submit to: AV Hospice Society
 Fax: 250-723-4471
 Email: office@albernihospice.ca
 Phone: 250-723-4478

Request for Services Form

(Allow two business days for AVHS to process the request)

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| <p style="color: red; font-size: small;">AVHS requires that referring parties gain consent from their client before making a referral. Have you gained consent from the client to make this referral? If you have signed consent, please send along with referral.</p> | <p style="font-size: small;">If yes, initial here: _____</p> |
|--|---|

| Referral Information | |
|----------------------------------|---------------------|
| Date of Referral: | Organization: |
| Person Making Referral: | Relation to Client: |
| Phone Number: | Email: |
| Reason for Third Party Referral: | |

| Information for Client Needing Services | |
|---|------------|
| Name: | D.O.B: |
| Address: | Email: |
| Phone Number: | Cellphone: |

| Client Care Information (If applicable) | |
|---|--|
| Diagnosis: | |

| Client Background Information / Reason for Referral |
|---|
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