

CR Mentor Study

Patient Information to Support Post-Discharge Phone Call by Peer Mentor

Mentor Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_

Date and Time of Scheduled Call: \_\_\_\_\_

Study Coordinator Name and Contact Information if needed: \_\_\_\_\_

CR referral has been received for the patient                      Yes    No

CR referral to UHN    Yes    No    N/A

CR referral to a site closer to home    Name: \_\_\_\_\_

If referred to UHN, has the patient has been invited to an education day                      Yes    No  
Date: \_\_\_\_\_

Has the patient attended education day    Yes    No

Comments: