

## SPECIALIZED GERIATRIC SERVICES

**REFERRAL FORM TEL:** (416) 756-6871

FAX: (416) 756-6438



## Please include related consultation notes and/or lab results

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Name of Client						м 🛭 ғ	
surname			first name				
Address					ON		
Street	Name and Number	Apartment		City	Prov.	Postal Code	
Phone #				Marital Status	S		
Health Card # / /		<del></del>		DOB			
		version code			d/m	/ y	
Contact Person for booking		Relationship		Phone #			
Is client/substitute decision maker agr	eeable to referral   Yes	□ No					
INSTRUCTIONS: Please indicate reason patient will have access to specialized geriatr							
REASON[S] FOR REFERRAL	MEDICAL INFORMATION		AM	AMBULATORY SERVICES			
[check all that applies]	Main Concern(s)						
☐ Medical/Physical			U		<b>Hospital</b> Interd ab and wellness p		
☐ Mobility				_	licine Clinic Con	_	
☐ Falls					geriatrician or C		
☐ Incontinence				Geriatric Psy	chiatry Clinic		
☐ Delirium					sult only (by Psy	chiatrist)	
☐ Pain management				OR	1. 0. 1	c 11	
☐ Medication/Polypharmacy	Medical History □ [do			Cons	sult & short term	follow up	
☐ Sleep	(please attach copy of C Profile[CPP] if available				ic Consult by inte	erdisciplinary	
☐ Weight loss/nutrition	1 rojue[C11] ij avaitabi	<i>e)</i>		team & geriatr			
☐ Cognitive/ Behavioural			<b>U</b>	Geriatric Parl	kinson's Clinic e assessment by p	physician &	
☐ Verbal/ Physical aggression				pharmacist.	e dissessment of p	ongoverant &	
☐ Cognition/Dementia					ducation & Ex.		
$\square$ Delusions/ Hallucinations				Pharmacist/Ph group education	ysiotherapist com	nsultation &	
☐ Depression						vention Clinic	
☐ Wandering	MEDICATIONS □ [de	ocumentation attached]		-	& Fracture Pre-	geriatrician and a	
☐ Psychosocial				pharmacist/nur		geriairieian ana a	
☐ Caregiver/Family issues							
☐ Elder Abuse				TREACH SER	<u>VICES</u>		
☐ Social isolation					licine Outreach al/functional ass		
☐ Functional					aı/junctionai ass COE physician e	•	
☐ ADL/IADL Decline					chiatry Outreac		
☐ Home safety				=	ment by a psych		
☐ Other (please specify):							
Name of Referring MD/NP (please print	nt)			Phone No.			
Signature of Referring MD/NP				<b>Date</b> (d/m/y)	)		
Name of Family MD/NP (please Print)				Phone No.			
Signature of Family MD/NP				Data (d/m/y	1		