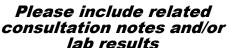


SPECIALIZED GERIATRIC SERVICES

REFERRAL FORM

TEL: (416) 756-6871 FAX: (416) 756-6438





	iad res	Suits				
Name of Client						м 🗆 ғ
surname		first name				
Address					ON	
Street 1	Name and Number	Apartment		City	Prov.	Postal Code
Phone #				Marital Status		
Health Card # / / /			DOB			
		version code			d / m /	'y
Alternate Person for booking	Relat	ionship		Phone #		
Is client/substitute decision maker agree	eable to referral 🗆 Yes 🗀 No	☐ Patient has pro	vided	verbal consent fo	or SGS to cont	act alternate
INSTRUCTIONS: Please indicate reason(
patient will have access to specialized geriatric	medicine and geriatric psychiatry se	rvices. Each referral will	be tric	iged to the most app	ropriate service(s).
REASON[S] FOR REFERRAL	MEDICAL INFORMATION		AM	BULATORY SE	RVICES	
[check all that applies]	Main Concern(s)			Contract Descrip	4-1 <i>7 1</i>	. 1.
☐ Medical/Physical			_	Geriatric Day Houtpatient rehab		
☐ Mobility				Geriatric Medic	•	0
☐ Falls				assessment by ge		
☐ Incontinence				Geriatric Psych	niatry Clinic	
☐ Delirium					t only (by Psyc	hiatrist)
☐ Pain management	Madical History	-4:44		OR Consul	t & short term	follow up
☐ Medication/Polypharmacy	Medical History ☐ [documents					•
☐ Sleep	(please attach copy of Cumulativ Profile[CPP] if available)	ve Patient		Memory Clinic		rdisciplinary
☐ Weight loss/nutrition	110ftte[C11] if available)			team & geriatric Geriatric Parkir		
☐ Cognitive/ Behavioural			_	Comprehensive of		hysician &
☐ Verbal/ Physical aggression				pharmacist.	<i>71</i>	
☐ Cognition/Dementia				☐ Neuro		COE
☐ Delusions/ Hallucinations			u	Parkinson's Edu Pharmacist/Phys		
☐ Depression				group education.		suitation &
☐ Wandering	MEDICATIONS [document	tation attached]		Osteoporosis &	Fracture Prev	ention Clinic
☐ Psychosocial				-		eriatrician and a
☐ Caregiver/Family issues				pharmacist/nurse	2	
☐ Elder Abuse			OI!	TDEACH CEDA	ICEC	
☐ Social isolation				TREACH SERV Geriatric Medic		Т
☐ Functional			_	In home medical,		
☐ ADL/IADL Decline				clinician &/or Co		
☐ Home safety				Geriatric Psychi	-	
☐ Other (please specify):				short term in hon assessment for he		•
Name of Referring MD/NP (please print	<i>t</i>)		I	Phone No.	port	
Signature of Referring MD/NP				Date (<i>d/m/y</i>)		
Name of Family MD/NP (please Print)				Phone No.		
Signature of Family MD/NP				Date (d/m/v)		