West Park HEALTHCARE CENTRE get your life back

West Park Geriatric Services Common Referral Form

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Services Requested: ☐ **Geriatric Interprofessional Assessment Clinic** FAX TO: 416-243-3907

Referral to Geriatric Clinic requires Doctor or Nurse Practitioner

☐ **Seniors Mental Health Service** (Outreach) FAX TO: 416-243-3735

Name of Client: _____ (*Surname*) _____ (*First Name*) ☐ **M** ☐ **F** ☐ **Other**

Address: _____ (*Street Name and Number*) _____ (*Apt.*) (*City*) (*Prov.*) _____ (*Postal Code*)

Tel #: _____ **Lives Alone?** ☐ **Yes** ☐ **No** ☐ **Lives with** _____ **Marital Status:** _____

Health Card #: _____ / _____ / _____ _____ (*Version Code*) **DOB:** _____ yyyy/mm/dd

Alternate Contact: _____ **Relationship:** _____ **Tel #:** _____

Contact Person for Booking Appointment: _____ **Translator required?** ☐ **Yes** _____ (*Language*)

Is client/substitute decision maker aware of referral? ☐ **Yes** ☐ **No** **Is patient homebound?** ☐ **Yes** ☐ **No**

Is Home Care involved? ☐**Yes** ☐**No** ☐**Unsure** **If yes, Case Manager Name:** _____ **Tel #:** _____

Potential safety risks for home or office visits ☐ **Yes** ☐ **No** **Please specify:** _____

REASON(S) FOR REFERRAL (CHECK ALL THAT APPLY)

☐ **MEDICAL / PHYSICAL → Indicate recent acute decline** ☐

- ☐ Mobility Decline / Falls
- ☐ Polypharmacy / Optimal Prescribing
- ☐ Multiple Chronic Health Conditions
- ☐ Weight Loss / Nutrition
- ☐ Incontinence
- ☐ Sleep
- ☐ Pain Management

☐ **COGNITIVE / BEHAVIOURAL → Indicate recent acute decline** ☐

- ☐ Cognitive Changes / Dementia
- ☐ Delusions / Hallucinations
- ☐ Challenging Behaviours (wandering, agitation, aggression, resistance to care, etc.)

☐ **OTHER** (please specify): _____

_____

☐ **PSYCHIATRIC / PSYCHOSOCIAL → Indicate recent acute decline** ☐

- ☐ Depression / Anxiety
- ☐ Specific Symptoms of Serious Mental Illness
- ☐ Psychiatric Medication Review
- ☐ Suicide / Self Harm
- ☐ Substance Abuse / Addictions
- ☐ Caregiver / Family Issues
- ☐ Elder Abuse
- ☐ Social Isolation
- ☐ Legal / Financial Issues
- ☐ Housing Concerns

Psychiatric Diagnosis ☐ Yes ☐ No ☐ Unknown

If yes, please specify: _____

Psychiatrist Name: _____

☐ **FUNCTIONAL → Indicate recent acute decline** ☐

- ☐ ADL / IADL Decline
- ☐ Home Safety

Urgency of Referral: ☐ **Routine Assessment** (Non-Urgent) ☐ **Urgent Intervention** (If urgent, select risk factors)

☐ Recurrent ED Visits ☐ Atypical cognitive changes (cause unclear) ☐ Caregiver Burnout ☐ Recent acute decline as indicated in reason for referral

Main Concern(s) to be addressed (Please attach all relevant notes / documentation / medication HX):

Referring Source: ☐ GP/NP ☐ Specialist ☐ Family/Caregiver/SDM ☐ Self ☐ Hospital ☐ Agency/Other _____

Name of Referring Source: _____ TEL # _____ FAX # _____

Name of GP: _____ TEL # _____ FAX # _____

Signature of Referral Physician *(if applicable)*: _____ Billing # _____ Date: yyyy/mm/dd