

**SPECIALIZED GERIATRICS
PHYSICIAN REFERRAL**

PATIENT/CLIENT DEMOGRAPHICS					RELATIONSHIP TO CLIENT/PATIENT				
NAME <input type="checkbox"/> M <input type="checkbox"/> F					Living Arrangement <input type="checkbox"/> With spouse <input type="checkbox"/> Alone <input type="checkbox"/> Other				
Address					Next of Kin/Primary Contact				
Telephone (Home)					Relationship to Client				
Date of Birth	Y	Y	Y	Y	M	M	D	D	Telephone (Home)
Health Card #								VERSION	Telephone (Other)
French Language Services Required? <input type="checkbox"/> Yes <input type="checkbox"/> No					TO BE COMPLETED BY PROVIDENCE CARE STAFF Interpreter <input type="checkbox"/> Family <input type="checkbox"/> Professional <input type="checkbox"/> Staff <input type="checkbox"/> Volunteer Format <input type="checkbox"/> Written <input type="checkbox"/> Verbal <input type="checkbox"/> Both				
REFERRAL INFORMATION (the following is to be filled in by the physician or nurse)									
Referral Source: (e.g. family physician, team nurse, CCAC)					Telephone:			Fax:	
IS FAMILY PHYSICIAN AWARE OF THIS REFERRAL? <input type="checkbox"/> Yes <input type="checkbox"/> No (If the family physician has not been made aware of the referral , please be advised it is part of Specialized Geriatrics practice to do so.) Family Physician Name _____ Telephone _____ Fax # _____ Address _____									
Reason for Referral: WHAT DO YOU WANT US TO TRY TO HELP WITH? What have you tried?									
Are there OTHER GERIATRIC ISSUES ? <input type="checkbox"/> Multiple medical concerns <input type="checkbox"/> Cognition <input type="checkbox"/> Falls <input type="checkbox"/> Medications <input type="checkbox"/> Depressed mood <input type="checkbox"/> Caregiver stress <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Driving <input type="checkbox"/> Safety concerns PLEASE ELABORATE: 									
Please provide any additional information that will be relevant to our assessment and the care of your patient. Please include current medical issues and medications. EMR PRINT-OUTS ARE VERY HELPFUL.									
Signature:					<input type="checkbox"/> MD <input type="checkbox"/> RN(EC)		Date		
							Y	Y	Y
							M	M	D

(If at all possible, please provide MD or RN(EC) signature.)

If there is a specific URGENCY, please telephone/fax and provide details
TELEPHONE (613) 544-7767 OR 1-800-214-5848
FAX (613) 544-4017

OF NOTE: If the reason for referral is dementia without concurrent medical issues or for behavioural issues related to dementia, consider referral to Geriatric Psychiatry in your area.