

GERIATRIC MEDICINE CLINIC REFERRAL FORM

Fax referral to Providence Care Central Intake 613-548-5595

Please note an incomplete referral form and missing documentation will result in requests for additional information and a delay in processing your 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	Telephone (Home)		
Health Card #	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: Please provide any additional information that will be relevant to our assessment and the care of your patient.			
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			
Signature:		<input type="checkbox"/> MD <input type="checkbox"/> RN(EC)	Date:

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

SPECIALIZED GERIATRICS

CONTINENCE CLINIC

Referral Criteria: Patients over 75 years of age with urinary incontinence issues.

Type of Service: Provides inter-professional assessment, diagnosis and treatment for elderly patients with urinary incontinence issues.

GERIATRIC MEDICINE CLINIC

Referral Criteria: High risk, frail elderly patients with multiple co-morbidities as well as memory and/or cognition issues.

Type of Service: Provides inter-professional assessment, diagnosis and stabilization to frail elderly patients and family.

MEMORY CLINIC

Referral Criteria: Individuals over 50 years of age with new onset memory and/or cognition issues not related to ABI or Psychiatric diagnoses.

Type of Service: Provides inter-professional assessment, diagnosis and recommendations for patients with memory and/or cognitive disorders.