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OFFICE USE ONLY: Date Received *(dd/mm/yy)*: ______________
Date Reviewed *(dd/mm/yy)*: ______________ ID#: ______________

Seniors' Health Services Referral Form

PLEASE COMPLETE ALL FIELDS AND SIGN THE FORM. MISSING OR INCOMPLETE INFORMATION WILL DELAY PROCESSING OF REFERRAL

Name of Client: ______________________________ ☐ M ☐ F
Surname *First Name*

Address: ______________________________
Street Number and Name *Apartment* *City* *Province* *Postal Code*

Phone: ______________________ Marital Status: ______________________

Health Card #: ________/________/________ ________ Date of Birth: ______________
Version Code *DD / MM / YYYY*

Person to contact re booking appointment: ______________ Phone *(daytime)*: ______________

Relationship to client: ______________ Phone *(evening)*: ______________

Client has been informed about the referral: ❒ no ❒ yes Is an interpreter required? ❒ no ❒ yes, specify: ______________

Is CCAC involved? ❒ no ❒ yes ❒ unsure If yes, name of Case Manager: ______________ Phone #: ______________

Does the client have a Substitute Decision Maker or Power of Attorney? ❒ unsure ❒ no ❒ yes (complete information below if different from above)

Name: ______________ Phone *(daytime)*: ______________ Phone *(evening)*: ______________

Reason for Referral (check all that apply):

❒ Functional Decline
❒ Incontinence
❒ Medication Management/ Polypharmacy
❒ Constipation
❒ Mobility / Gait
❒ Weight Loss/Nutrition
❒ Falls
❒ Cognitive Impairment
❒ Psychosocial
❒ Other (specify): ______________

Main Concern(s) to be addressed: ______________

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Indicate the service of preference (check all that apply):

❒ **Seniors' Health Clinic:** ❒ Routine ❒ Urgent (2-3 weeks)
Comprehensive geriatric consultation with NP and/or MD

❒ **Falls Prevention/Bone Health Program:** *Consultation with NP and/or MD and PT and 6 week exercise/education program; client must be able to walk 25 m and learn new information.*

❒ **Regional Continence Clinic *(Nurse led)*:** *consultation and education*

❒ **Regional Continence Home Visits:** *consultation and education for moderately to severely, housebound frail seniors*

❒ **Regional Seniors' Health Outreach:** *In home medical/physical, cognitive, functional and psychosocial consultation by NP, OT, SW and/or Pharmacist; If client is not housebound, specify why reason home visit required:*

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Medical History: ❒ See Attached

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Medications: ❒ See Attached

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Infection Control: Has the client ever had any of the following infections (check all that apply)?
❒ MRSA ❒ VRE ❒ c. Difficile ❒ TB ❒ ESBL

Referral from: ❒ Emergency Dept ❒ Acute Care ❒ Primary Healthcare ❒ Community Agency ❒ Self/Family

Name of Family MD *(please print)*: ______________ Phone: ______________ Fax: ______________

Name of Referring MD *(please print)*: ______________ Phone: ______________ Fax: ______________

Signature of Referring MD ______________ OHIP Billing #: ______________ Date *(dd/mm/yy)*: ______________

Please fax with relevant notes, recent lab results and/or ECG. # of pages being faxed: __________

***Please note, that* after receiving this consult request we will contact your patient directly. Thank you.**