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Trillium HEALTH CENTRE

Seniors' Health Services Referral Form

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

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

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: _____

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:* _____

Medical History: ❒ See Attached

Medications: ❒ See Attached

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.**