

Seniors' 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 #: _____ / _____ / _____ *Version Code* Date of Birth: _____
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):

<input type="checkbox"/> Functional Decline	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Medication Management/ Polypharmacy	<input type="checkbox"/> Constipation
<input type="checkbox"/> Weight Loss/Nutrition	<input type="checkbox"/> Mobility / Gait
<input type="checkbox"/> Cognitive Impairment	<input type="checkbox"/> Falls
<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Psychosocial

Main Concern(s) to be addressed: _____

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

Seniors' Health Clinic: Routine Urgent
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.