

SPECIALIZED GERIATRIC CLINIC PATIENT REFERRAL

Please **Fax** completed form to **519-464-4544**.

Ensure a medication list and recent lab work are included as part of the referral.

Please call 519-464-4400 ext. 8532 with any questions you may have.

PATIENT INFORMATION			
Last name:	First name:	Gender:	Age:
Address:	Phone:	Date of birth: (YYYY/MM/DD)	Is interpreter required? Yes <input type="checkbox"/> No <input type="checkbox"/> Language: _____
Health card:	Version code:	Has client/family been informed of this referral? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Living Arrangements: <input type="checkbox"/> Alone <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Family <input type="checkbox"/> LTC			Is LHIN Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No
CONTACT INFORMATION (*Required)			
**Primary contact:	Relationship to patient	Phone number #1	Address
Secondary contact:	Relationship to patient	Phone number #1	Address
REASON FOR REFERRAL (check all that apply):			
<i>If you are concerned about acute delirium, please refer patient to Emergency Department for assessment.</i>			
<input type="checkbox"/> Cognitive assessment/dementia <input type="checkbox"/> Cognitive/personality changes <input type="checkbox"/> Depression or anxiety <input type="checkbox"/> Behaviours associated with dementia <input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Weight Loss/Gain <input type="checkbox"/> Mobility and falls <input type="checkbox"/> Multiple presentations to acute care/ED <input type="checkbox"/> Complex medical problems <input type="checkbox"/> Functional decline	<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Polypharmacy <input type="checkbox"/> Caregiver stress/fatigue	
Please provide details regarding the primary goals for referral:			
Please check off all community agencies with whom the patient has been linked.			
<input type="checkbox"/> Alzheimer's Society First Link <input type="checkbox"/> Behavioural Response Team <input type="checkbox"/> Canadian Mental Health Association <ul style="list-style-type: none"> <input type="checkbox"/> Community Psychiatry Services <input type="checkbox"/> Reach Out 	<input type="checkbox"/> Police Services <input type="checkbox"/> Urgent Consultation Service, Mental Health, BWH <input type="checkbox"/> Home and Community Care <input type="checkbox"/> BSO Representative in LTC facility <input type="checkbox"/> Other (please list here)		



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Are there risk issues?

- Suicidal/Homicidal Ideation
- Falls
- Home Safety Concerns
- Aggression
- Other _____

Relevant Clinical and History of Presenting Illness: Past medical history and active problems.

Please include treatments or therapies trialed in the past 6 months.

- Please see attached

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH THE REFERRAL:

- 1. Medication list** (including vitamins, OTCs and recent trials)
Patients' Pharmacy (if known): _____
- 2. Recent blood work including:** CBC & diff., lytes, TSH, glucose, Vit B12, ionized calcium, creatinine, urea **or**
 - Blood work pending**
**This list of blood work is recommended by the Canadian Consensus Guidelines on Dementia as the basic screening blood work for patients with cognitive impairment (Chertkow, H. et al., 2008, CMAJ, 173(3))*
- 3. All relevant consult notes, CTs, X-rays, MRIs, ECGs, Echo reports, BMDs** (if not available through the Bluewater Health electronic records)
- 4. Copies of memory and mood screening completed in the past year.**

REFERRING PRACTITIONER INFORMATION

PRINT Physician/Nurse Practitioner name:			Physician/Nurse Practitioner SIGNATURE:
Office Address:			Billing number:
Phone:	Fax:	Date of referral:	Primary Care Practitioner (if other than the referring practitioner):

WHAT HAPPENS NEXT?

We will contact you within 7 business days to confirm receipt of your referral and to request missing information. You will receive a notification of triage decision. **To expedite this process, please ensure that you have provided all requested clinical information and contact information with this referral.**

