BLUEWATER HEALTH

Patient Label Here

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 ☐ No ☐ Language:________________
Health card:	Version code:	Has client/family been informed of this referral? Yes ☐ No ☐	
CONTACT INFORMATION *(*Required)*			
*Primary contact:	Relationship to patient	Phone number #1	Phone number #2
Secondary contact:	Relationship to patient	Phone number #1	Phone number #2

REASON FOR REFERRAL (check all that apply):
If you are concerned about acute delirium, please refer patient to Emergency Department for assessment.

- ☐ Cognitive assessment/dementia
- ☐ Cognitive/personality changes
- ☐ Depression or anxiety
- ☐ Behaviours associated with dementia
- ☐ Parkinson's disease
- ☐ Weight Loss/Gain
- ☐ Mobility and falls
- ☐ Multiple presentations to acute care/ED
- ☐ Complex medical problems
- ☐ Functional decline
- ☐ Osteoporosis
- ☐ Polypharmacy
- ☐ 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.

- ☐ Alzheimer's Society First Link
- ☐ Behavioural Response Team
- ☐ Canadian Mental Health Association
  - ☐ Community Psychiatry Services
  - ☐ Reach Out
- ☐ Police Services
- ☐ Urgent Consultation Service, Mental Health, BWH
- ☐ Home and Community Care
- ☐ BSO Representative in LTC facility
- ☐ Other (please list here)

BLUEWATER HEALTH

Patient Label Here

SPECIALIZED GERIATRIC CLINIC PATIENT REFERRAL

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.**

RH00693