HÔTEL-DIEU
ESTD GRACE 1888
HEALTHCARE

GERIATRIC OUTPATIENT SERVICES REFERRAL FORM

Tayfour Campus, 1453 Prince Road
Windsor, Ontario N9C 3Z4
Telephone: 519-257-5111 Ext. 76955 Fax: 519-257-5197

Please indicate the primary program your referral is intended for:

☐ Geriatric Assessment Program (GAP)
☐ Geriatric Mental Health Outreach Team (GMHOT)

Please ensure referral form is completely filled out prior to sending.

PATIENT INFORMATION			
Last Name:	First Name:	Gender:	Age:
Address:	Phone:	Date of Birth:	Is Interpreter Required ☐ Yes ☐ No Language: _____
Health Card:	Version Code:	Has client/family been informed of this referral? ☐ Yes ☐ No	
LTC Home (if applicable) when referring to GMHOT			Room #

CONTACT INFORMATION			
Primary Contact	Relationship with patient	Phone Number #1	Phone Number #2
Secondary Contact	Relationship with patient	Phone Number #1	Phone Number #2

PRIMARY REASONS FOR REFERRAL (check all that apply)

Previously involved with our services: ☐ Yes Date/Program _____ ☐ No

☐ Cognitive assessment/dementia	☐ Mobility and falls	☐ Delusions/Hallucinations
☐ Personality changes	☐ Fraility	☐ Depression or anxiety
☐ Polypharmacy	☐ Parkinson's disease	☐ Paranoia/Suspicion
☐ Functional decline	☐ Multiple presentations to acute care/ED	☐ Physically/Verbally Responsive/Expressive
☐ Complex medical problems	☐ Other: _____	

SECONDARY REASONS/CONCERNS FOR REFERRAL (check all that apply)

☐ Weight Loss/Gain	☐ Sleep
☐ Caregiver Stress/fatigue	☐ Pain Management
☐ Drug/Alcohol Issues	☐ Other: _____

Relevant Clinical History

Please provide details regarding the primary GOALS for referral: / What is the question you would like us to answer?

Please check off all community agencies with whom the patient has been linked.

☐ Alzheimer's Society First Link	☐ Police Services	☐ VON
☐ Behaviour Supports Ontario (BSO)	☐ SW LHIN Home and Community Care	☐ WECHC
☐ Canadian Mental Health Association (CMHA)	☐ COAST (City)	☐ Other (Please list here)
☐ Transitional Stability Centre (TSC)	☐ MHRU – Mental Health Response Unit (County)	☐ _____
☐ Family Service Windsor		☐ _____

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Are there risk issues?

☐ Suicidal/Homicidal Ideation	☐ Failing to Thrive	☐ Illegal Drugs
☐ Falls	☐ Smoking	☐ Wandering
☐ Home Safety Concerns	☐ Alcohol	☐ Other: _____

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH THE REFERRAL:

1. **Past Medical History (REQUIRED)**
2. **Medication list (including vitamins, OTCs, dosage and frequency) (REQUIRED)**
3. **Recent lab work including** (within 6 months): **(REQUIRED)**

   CBC & DIFF., lytes, TSH, glucose, Vit B12, ionized calcium, creatinine, urea.

   This list of blood work is recommended by the Canadian Consensus Guidelines on Dementia (Chetkow, H. et al., Jan. 29, 2008, CMAJ, Vol 173, No.3) as basis screening blood work for patients with cognitive impairment.
4. **All relevant consult notes, CTs, X-rays, MRIs, ECGs, Echo reports**
5. **Copies of memory and mood screening completed in the past year.**

ADDITIONAL QUESTIONS – IF REFERRED BY A PSYCHIATRIST (COMPLETION REQUIRED)

Length of time as Care Provider for this patient: _____

Duration of Current Symptoms: ☐ Recent ☐ < 2 years ☐ > 2 years

What are your expectations of program involvement?

- ☐ Second opinion by Psychiatrist
- ☐ Short term Social Work intervention
- ☐ Other: _____

What Medications have been tried, dosage and with what results:

_____

_____

What types of Psychotherapy have been tried? ☐ Individual ☐ Group ☐ Self-Help ☐ Other

Please note that program participation is time-limited and upon completion of the program the patient you are referring will be discharged back into your care.

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 referring practitioner):

WHAT HAPPENS NEXT?

We will contact you within **5 business days** to confirm receipt of your referral or to request missing information. **To expedite this process, please ensure that you have provided all requested clinical information and contact information with this referral.**