HÔTEL-DIEU
ESTD GRACE 1888
HEALTHCARE

***PLEASE DO NOT FAX THIS PAGE WITH YOUR REFERRAL FORM**
The referral form is available at this link: https://www.hdgh.org/geriatricassessmentprog

Welcome to Hôtel-Dieu Grace Healthcare (HDGH)
Specialized Geriatric Services Available:

A client, aged 65 years + and under the care of a Primary Care Provider, may be eligible for services to GAP or GMHOT based on the information gathered and in consultation with service providers.

1. **Geriatric Assessment Program (GAP)**: A voluntary, short-term program delivered by an interdisciplinary team who provides a specialized comprehensive geriatric assessment for older adults (age 65+) who are exhibiting progressive cognitive changes where a diagnosis of dementia has not yet been established.

   Inclusion Criteria:
   - Progressive cognitive decline (dementia not previously diagnosed)
     - Functional decline due to cognitive changes

   Exclusion Criteria:
   - Acute delirium
   - Active alcohol or substance use
   - Post major surgery (3-4 months)
   - Post stroke/acute brain injury (3-4 months)
   - Resides outside of Windsor-Essex County

2. **Geriatric Mental Health Outreach Team (GMHOT)**: A voluntary, short-term program that works to enhance the mental health and well-being of individuals 65+ living at home in the community, or in long-term care homes, who exhibit significant mental health issues and/or behavioural expressions associated with cognitive impairment.

   Inclusion Criteria:
   - BPSD (Behavioural and Psychological Symptoms of Dementia)
   - Depression/Anxiety
   - Symptoms of Psychosis
   - Complex Mental Health Concerns
   - Frequent trips to emergency or frequent hospitalizations due to mental health concerns

   Exclusion Criteria:
   - Acute delirium
   - Individual referred has a community Psychiatrist
     - *Exception: Unless referral comes from a Psychiatrist requesting a second opinion
   - Resides outside of Windsor-Essex County

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SPECIALIZED GERIATRIC SERVICES
GAP OR GMHOT REFERRAL FORM

Tayfour Campus, 1453 Prince Road
Windsor, Ontario N9C 3Z4
Telephone: 519-257-5112 Fax: 519-258-5242

CLIENT INFORMATION			
The client should be 65 years or older and under the care of a PCP to be eligible for services			
Last Name:	First Name:	Date of Birth (MM/DD/YYYY):	Gender:
Street Address:	City, Town:	Postal Code:	
Health Card:	Version Code:	Is the patient capable of consenting and making their own decisions? ☐ **Yes** ☐ **No**	
Primary Phone Number:	Phone Number #2:		
Who will be contacted to schedule an assessment? ☐ **Patient** ☐ **Alternate Contact – Substitute Decision Maker (SDM) or** ☐ **Not applicable**			
*** ALTERNATE CONTACT INFORMATION, if applicable**			
Last name:	First Name:	Relationship with Client:	This person is the: ☐ **SDM or** ☐ **Other**
Primary Phone Number:	Phone Number #2:		
Street Address:	City, Town:	Postal Code:	
The REFERRING PROVIDER is responsible for informing the client or SDM/other to obtain consent for this referral to our programs and services offered. Consent obtained for this referral? ☐ **Yes**			
PRIMARY REASON(S) FOR REFERRAL			
Geriatric Assessment Program (GAP)	**Geriatric Mental Health Outreach Team (GMHOT)**		
☐ Progressive Cognitive Decline (Dementia not previously diagnosed): ☐Functional decline due to cognitive changes	☐ Behavioral Psychological Symptoms of Dementia (BPSD) ☐ Depression	☐ Anxiety ☐ Symptoms of Psychosis ☐ Complex Mental Health Concerns	
Please provide details regarding the **GOALS** for this referral. What is the expectation of program involvement?			

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Please check off all community agencies with whom the client has been linked: □ **Ontario Health at Home** □ **Community Paramedic Team** □ **CMHA** □ **Alzheimer's Society** □ **Behavioural Supports Ontario** □ **Other – Please specify:**	
Does the client reside in Long Term Care? □ **Yes** □ **No**	
Are there home safety concerns? □ **Yes** □ **No** **If yes, please provide concerns:**_____ _____	
Is the client medically cleared for exercise? (GAP) □ **Yes** □ **No**	
Has delirium been ruled out? □ **Yes** □ **No**	
Has the client seen a geriatrician, neurologist, or psychiatrist for the same concerns in the last 2 years? □ **If Yes please send these consult notes** □ **No** Is client already followed by a community psychiatrist? □ **Yes** □ **No**	
REQUIRED	Attach a list of ALL medications, including vitamins and supplements. Attach past medical history and most recent labs (CBC & DIFF. lytes, TSH, glucose, Vit B12, ionized, calcium, creatinine, and urea).
REQUIRED	Attach a copy of recent lab work that has been completed **within the past 6 months** of the date this referral is received. It must include CBC & DIFF. lytes, TSH, glucose, Vit B12, ionized, calcium, creatinine, and urea.
If needed, and unless otherwise noted, only relevant personal health information may be shared with our current or potential circle of care providers to coordinate appropriate care, in accordance with PHIPA.	
REFERRING PRACTITIONER INFORMATION	
Are you the patient's Primary Care Provider (PCP)? □ **Yes** □ **No** **If no, please note the PCP** _____	
Referring Provider (print) - Physician or Nurse Practitioner Name:	Office Address:

Signature	Billing# (**Required**):	Phone Number:	Fax Number:

Your office will receive confirmation that the referral was received or request missing information.