

**\*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



## SPECIALIZED GERIATRIC SERVICES

### GAP OR GMHOT REFERRAL FORM

Tayfour Campus, 1453 Prince Road

Windsor, Ontario N9C 3Z4

Telephone: 519-257-5112 Fax: 519-257-5242

| CLIENT INFORMATION                                                                                                                                                                                                            |               |                                                                                                                               |                                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| <i>The client should be 65 years or older and under the care of a PCP to be eligible for services</i>                                                                                                                         |               |                                                                                                                               |                                                                                                                                               |
| 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? <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                               |
| Primary Phone Number:                                                                                                                                                                                                         |               | Phone Number #2:                                                                                                              |                                                                                                                                               |
| Who will be contacted to schedule an assessment?<br><input type="checkbox"/> Patient <input type="checkbox"/> Alternate Contact – Substitute Decision Maker (SDM) or <input type="checkbox"/> Not applicable                  |               |                                                                                                                               |                                                                                                                                               |
| <b>* ALTERNATE CONTACT INFORMATION, if applicable</b>                                                                                                                                                                         |               |                                                                                                                               |                                                                                                                                               |
| Last name:                                                                                                                                                                                                                    | First Name:   | Relationship with Client:                                                                                                     | This person is the:<br><input type="checkbox"/> SDM or <input type="checkbox"/> Other                                                         |
| Primary Phone Number:                                                                                                                                                                                                         |               | Phone Number #2:                                                                                                              |                                                                                                                                               |
| Street Address:                                                                                                                                                                                                               |               | City, Town:                                                                                                                   | Postal Code:                                                                                                                                  |
| <i>The REFERRING PROVIDER is responsible for informing the client or SDM/other to obtain consent for this referral to our programs and services offered.</i> Consent obtained for this referral? <input type="checkbox"/> Yes |               |                                                                                                                               |                                                                                                                                               |
| <b>PRIMARY REASON(S) FOR REFERRAL</b>                                                                                                                                                                                         |               |                                                                                                                               |                                                                                                                                               |
| <b>Geriatric Assessment Program (GAP)</b>                                                                                                                                                                                     |               | <b>Geriatric Mental Health Outreach Team (GMHOT)</b>                                                                          |                                                                                                                                               |
| <input type="checkbox"/> <u>Progressive</u> Cognitive Decline (Dementia not previously diagnosed):<br><input type="checkbox"/> Functional decline due to cognitive changes                                                    |               | <input type="checkbox"/> Behavioral Psychological Symptoms of Dementia (BPSD)<br><input type="checkbox"/> Depression          | <input type="checkbox"/> Anxiety<br><input type="checkbox"/> Symptoms of Psychosis<br><input type="checkbox"/> Complex Mental Health Concerns |
| Please provide details regarding the <b>GOALS</b> 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: <input type="checkbox"/> Ontario Health at Home<br><input type="checkbox"/> Community Paramedic Team <input type="checkbox"/> CMHA <input type="checkbox"/> Alzheimer's Society <input type="checkbox"/> Behavioural Supports Ontario<br><input type="checkbox"/> Other – Please specify: _____ |                                                                                                                                                                                                                                   |                 |             |
| Does the client reside in Long Term Care? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                   |                 |             |
| Are there home safety concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide concerns: _____<br>_____                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                   |                 |             |
| Is the client medically cleared for exercise? (GAP) <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                   |                 |             |
| Has delirium been ruled out? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                   |                 |             |
| Has the client seen a geriatrician, neurologist, or psychiatrist for the same concerns in the last 2 years?<br><input type="checkbox"/> If Yes please send these consult notes <input type="checkbox"/> No                                                                                                                                                                    |                                                                                                                                                                                                                                   |                 |             |
| Is client already followed by a community psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <b>within the past 6 months</b> 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.                                                                                                                                                               |                                                                                                                                                                                                                                   |                 |             |
| <b>REFERRING PRACTITIONER INFORMATION</b>                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                   |                 |             |
| Are you the patient's Primary Care Provider (PCP)? <input type="checkbox"/> Yes <input type="checkbox"/> 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.                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                   |                 |             |

