Urgent Geriatric Clinic Referral

Phone: 705-728-9090 Ext: 23300
Fax: 705-728-3039

Referring Physician: _____ Discipline: _____ Date: _____ (dd/mm/yyyy)

Patient Name: _____ D.O.B _____ (dd/mm/yyyy)

Health Card Number: _____ Version Code _____ Phone Number: _____

Inclusions:

65 years of age or older? ☐ Yes ☐ No

Relevant Labs Included? ☐ Yes ☐ No

- CBC, Lytes, Bun, Cr, Ca, Mg, Phos, TSH, Alb, B12, Ferritin

Relevant Imaging Studies Included? ☐ Yes ☐ No

- If there is no CT Head please arrange prior to appointment

*If any boxes checked NO further information may be required or the referral may not be processed.

Exclusions: if the patient is a resident of a LTC facility

Reason for Referral:

☐ Memory Impairment
☐ Behavioral concerns
☐ Medication review
☐ Advanced care planning
☐ Parkinson's Management
☐ Falls (if this is your only concern please refer to the regional falls clinic)
☐ Home safety

☐ Greater than 2 or more emergency department visits in 3 months. Reasons: _____

_____

☐ Other/details: _____

_____

_____

Please include:

☐ Previous Consultation Notes (Including Neurology assessment, Falls Clinic Consult, Psychiatry, etc.)
☐ Complete Health History
☐ Medication List
☐ Cognitive Testing
☐ Behavior support services documentation
☐ Cardiac Workup
☐ Any other relevant imaging and/or lab work

**Patient must be accompanied by family member/friend at time of appointment.

Signature Referring Physician: _____ Billing Number: _____

Telephone Number: _____ Fax Number: _____

Triage:	*Referral appropriate:*
☐ Initial assessment with NP (1.5 hours) ☐ Follow-up appointment with Geriatrician (45 min)	☐ Yes ☐ No, why: _____