NORTH YORK GENERAL
Making a World of Difference

SPECIALIZED GERIATRIC SERVICES REFERRAL FORM

TEL: (416) 756-6871
FAX: (416) 756-6438

Please include related consultation notes and/or lab results

REGIONAL GERIATRIC PROGRAM OF TORONTO

Name of Client ..... ☐ M ☐ F
surname *first name*

Address ..... ON .....
Street Name and Number *Apartment* *City* *Prov.* *Postal Code*

Phone # ..... **Marital Status** .....

Health Card # __ __ __ __ / __ __ __ / __ __ __ __ __ **DOB** .....
version code *d / m / y*

Contact Person for booking ..... **Relationship** ..... **Phone #** .....

Is client/substitute decision maker agreeable to referral ☐ **Yes** ☐ **No**

INSTRUCTIONS: *Please indicate reason(s) for referral, complete the medical information section and check preferred service. By completing this referral form, your patient will have access to specialized geriatric medicine and geriatric psychiatry services. Each referral will be triaged to the most appropriate service(s).*

REASON[S] FOR REFERRAL
[check all that applies]

- ☐ **Medical/Physical**
  - ☐ **Mobility**
  - ☐ **Falls**
  - ☐ **Incontinence**
  - ☐ **Delirium**
  - ☐ **Pain management**
  - ☐ **Medication/Polypharmacy**
  - ☐ **Sleep**
  - ☐ **Weight loss/nutrition**
- ☐ **Cognitive/ Behavioural**
  - ☐ **Verbal/ Physical aggression**
  - ☐ **Cognition/Dementia**
  - ☐ **Delusions/ Hallucinations**
  - ☐ **Depression**
  - ☐ **Wandering**
- ☐ **Psychosocial**
  - ☐ **Caregiver/Family issues**
  - ☐ **Elder Abuse**
  - ☐ **Social isolation**
- ☐ **Functional**
  - ☐ **ADL/IADL Decline**
  - ☐ **Home safety**
- ☐ **Other** *(please specify)*:----------

MEDICAL INFORMATION

Main Concern(s)

Medical History ☐ **[documentation attached]**

(please attach copy of Cumulative Patient Profile[CPP] if available)

MEDICATIONS ☐ **[documentation attached]**

AMBULATORY SERVICES

- ☐ **Geriatric Day Hospital** *Interdisciplinary outpatient rehab and wellness program.*
- ☐ **Geriatric Medicine Clinic** *Comprehensive assessment by geriatrician and nurse.*
- ☐ **Geriatric Psychiatry Clinic**
  - ☐ Consult only (by Psychiatrist)
    OR
  - ☐ Consult & short term follow up
- ☐ **Memory Clinic** *Consult by interdisciplinary team & geriatric physician.*
- ☐ **Geriatric Parkinson's Clinic** *Comprehensive assessment by physician & pharmacist.*
- ☐ **Parkinson's Education & Ex. Program** *Pharmacist/Physiotherapist consultation & group education.*
- ☐ **Osteoporosis & Fracture Prevention Clinic** *Comprehensive assessment by geriatrician and a pharmacist/nurse*

OUTREACH SERVICES

- ☐ **Geriatric Medicine Outreach Team** *In home medical/functional assessment by clinician &/or COE physician/NP.*

Name of Referring MD/NP (***please print***) ..... **Phone No.** .....

Signature of Referring MD/NP ..... **Date** (*d/m/y*) .....

Name of Family MD/NP ***(please Print)*** ..... **Phone No.** .....

Signature of Family MD/NP **Date** (*d/m/y*)

Geriatricians: *Dr. Amanda Goldberg, Dr. Nihal Haque, Dr. Bianca Petrut, Dr. Stephanie Siu*
Psychiatrists: *Dr. Catherine Cheng, Dr. Goran Eryavec, Dr. Franklin Wong*
Care of Elderly: *Dr. Ruth Chiu, Dr. Mihaela Cordos, Dr. Serina Dai, Dr. Ananthavalli Kumarappah, Dr. Adelaida Neata*

Neurologist: *Dr. Joyce Tang*
NP *(Outreach Team): Donna Ruffo*