

Outpatient Specialized: Geriatric Services Referral

Address: Oakville Trafalgar Memorial Hospital, 3001 Hospital Gate, Oakville, ON L6M 0L8 Clinic Phone: 905-338-4362 Fax: 905-815-5130		Referral Source <input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient	Please complete all fields and sign form. Missing or incomplete information will delay processing of referral
Personal Information			
Name of Patient		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Health Card Number		Date of Birth	
Address			
Phone Number		Marital Status	
Person to Contact/Relationship to Patient (Mandatory)		Phone	Patient has been informed about referral: <input type="checkbox"/> Yes <input type="checkbox"/> No
Living Arrangements: <input type="checkbox"/> Alone <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Family <input type="checkbox"/> LTC Is CCAC Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No		Language: _____ Is an interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Referral Information			
Referral Source: <input type="checkbox"/> Physician Office <input type="checkbox"/> Outreach Team <input type="checkbox"/> ER <input type="checkbox"/> LTC <input type="checkbox"/> CCAC <input type="checkbox"/> Inpatient <input type="checkbox"/> Other: _____			
Referring Physician:	Phone:	Fax:	
Referring Physician Signature:	Date of Referral:	Billing Number:	
Name of Family Doctor	Phone:	Fax:	
Main Concerns: Please note – in order for referral to be processed in a timely manner, all information must be completed. _____ _____			
Check all applicable boxes <input type="checkbox"/> Falls <input type="checkbox"/> Failure to Cope <input type="checkbox"/> Function Decline <input type="checkbox"/> Mobility concerns <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Caregiver Stress <input type="checkbox"/> Polypharmacy <input type="checkbox"/> Osteoporosis Mgmt <input type="checkbox"/> Atypical fractures <input type="checkbox"/> Multiple fractures <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Other (specify): _____	Please select from the following: (Your referral will be triaged to the appropriate clinic) <input type="checkbox"/> GERIATRIC ASSESSMENT – Comprehensive geriatric assessment (Geriatrician, Nurse Practitioner) Please indicate location preference: <input type="checkbox"/> Oakville Trafalgar Memorial Hospital <input type="checkbox"/> Milton District Hospital <input type="checkbox"/> Georgetown Hospital <input type="checkbox"/> URGENT GERIATRIC CARE CLINIC – Comprehensive geriatric assessment for more urgent Geriatric issues (Geriatrician, Nurse Practitioner) <input type="checkbox"/> COMPLEX OSTEOPOROSIS CLINIC – Comprehensive skeletal assessment in the elderly with metabolic bone disease (Geriatrician, Nurse Practitioner, Physiotherapist) <input type="checkbox"/> FALLS PREVENTION CLINIC / EXERCISE CIRCUIT - Consultation with Geriatrician, Nurse Practitioner and Physiotherapist in the Clinic. This is followed by a 6-week exercise/education program if eligibility criteria are met. (Client must be able to walk 25 meters and learn new information) <input type="checkbox"/> PRE-OPERATIVE ASSESSMENT CLINIC – assessment with Nurse Practitioner and Geriatrician Please indicate reason for referral: <input type="checkbox"/> Optimization prior to pending surgery <input type="checkbox"/> Opinion of risks vs benefits of proceeding with surgical intervention <input type="checkbox"/> GERIATRIC MEDICINE OUTREACH PROGRAM – home visits by Multidisciplinary Team, in collaboration with Geriatrician - PLEASE USE TRILLIUM SENIORS SERVICES REFERRAL FORM		
Urgency Of Referral	<input type="checkbox"/> Routine Assessment		
	<input type="checkbox"/> Crisis Intervention – Risk Factors:	<input type="checkbox"/> Recent Hospitalizations <input type="checkbox"/> At Risk For LTC Placement	<input type="checkbox"/> ER Visits <input type="checkbox"/> Failure to Thrive
History			
Past Medical History: _____			
Specialists Involved In Care: _____			
Medications: _____			
Infection Control: Has the patient ever had any of the following infections (check all that apply)? <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> C. Difficile <input type="checkbox"/> TB <input type="checkbox"/> ESBL			

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