

GREY BRUCE GERIATRIC SERVICES INTEGRATED REFERRAL FORM

PHONE: 519-376-2121 ext. 2436

FAX: 519-378-1478

The patient's personal health information may be shared with any of the providers listed to determine the most appropriate ambulatory geriatric service in accordance with the *Personal Health Information Protection Act* (PHIPA):

- Behavioural Supports Ontario (BSO) Team at Brightshores Health System
- Geriatric Resource Nurses (GRNs) employed by St. Joseph's Health Care London
- Geriatricians-Brightshores Health System, Listowel Wingham Hospitals Alliance

PATIENT INFORMATION

Last name	First name	Gender:	Has Patient/SDM consented to this referral? <input type="checkbox"/> Yes <input type="checkbox"/> No
Address:	Phone Number 1: Phone Number 2:	Preferred Language:	
Health card (including version code)	Date of birth: YYYY/MM/DD	Person to contact about referral: <input type="checkbox"/> Patient <input type="checkbox"/> Alternate contact	

ALTERNATE CONTACT

Name	Relationship to patient	Phone number:
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REASONS FOR REFERRAL (check all that apply)

<input type="checkbox"/> Cognitive concerns <input type="checkbox"/> Personality changes <input type="checkbox"/> Mood (depression, anxiety) <input type="checkbox"/> Mobility evaluation, recurrent falls <input type="checkbox"/> Osteoporosis, fractures <input type="checkbox"/> Complex medical history <input type="checkbox"/> Frailty, functional decline <input type="checkbox"/> Recurrent hospitalizations, ED visits <input type="checkbox"/> Medication review/polypharmacy <input type="checkbox"/> Driving concerns	<input type="checkbox"/> Safety concerns (please specify): <input type="checkbox"/> Home visit required (please specify why): <input type="checkbox"/> Responsive behaviours due to diagnosed dementia, mental health and/or addictions? <input type="checkbox"/> Yes <input type="checkbox"/> No Current diagnosis: _____ If yes, please outline specific behavioural concerns: _____
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PRIMARY GOAL OF REFERRAL (main clinical question/concern, presenting illness/diagnosis):

Has the patient had a local memory clinic assessment? <input type="checkbox"/> Yes (<i>Please attach clinic notes and testing</i>) <input type="checkbox"/> No Please ensure and attach for <u>timely review of referral</u> : <input type="checkbox"/> Patient profile with health history and medication list <input type="checkbox"/> Updated geriatric screening lab work: CBC, electrolytes (including bicarbonate, Mg, Phos, Ca), BUN, Creatinine, ALT, TSH, B12, A1C, Urinalysis & culture <input type="checkbox"/> Head imaging (PLEASE ORDER if not completed in past 2 years) <input type="checkbox"/> Any relevant notes including past memory clinic notes, cognitive/mood testing, if available

REFERRAL SOURCE

Name (PRINT): Organization: Contact #: Primary Care Provider (if not referrer): Primary Care Team Affiliation (FHT, FHO, CHC): Please specify:	Physician/Nurse Practitioner SIGNATURE (<i>not required for BSO service</i>) X _____	
	If verbal order, taken by:	
	Office Address:	
	Phone:	Fax:
	Billing number:	
Date of Referral: YYYY/MM/DD		

The Intake and access of referrals is completed by Grey Bruce Geriatric Services. We work in partnership with the GERIATRIC AMBULATORY ACCESS TEAM (GAAT) at St. Joseph's Health Care London for regional geriatric services not provided locally. If your patient requires a regional service, your referral will automatically be forwarded to GAAT by Grey Bruce Geriatric Services.