AMBULATORY GERIATRIC SERVICES COMMON REFERRAL FORM - Toronto Grace - Fax to 647-689-3554

Name of Client: _____ _____ ☐ **M** ☐ **F** ☐ **Other**_____
Surname *First Name* ☐ **Trans (M→F)** □ **Trans (F→M)**

Address: _____ _____ _____ ON _____
Street Name and Number *Apt.* *City* *Prov* *Postal Code*

Tel #: _____ **Lives Alone? □ Yes □ No** **Marital Status:** _____

Health Card #: _____/_____/_____ _____ **DOB:** _____
Version Code *dd/mm/yy*

Alternate Contact: _____ **Relationship:** _____ **Tel #:** _____

Contact Person for Booking Appointment: _____ **Translator required? □ Yes** _____ **□No**
Language

Is client/substitute decision maker aware of referral? □ Yes □ No **Is patient homebound? □ Yes □ No**

Is Home & Community Care involved? □Yes □No □Unsure _____ _____

REASON(S) FOR REFERRAL
(Check all that apply)

Rapid Decline?

- **□ Medical / Physical** → **□**
  - **□ Mobility**
  - **□ Falls**
  - **□ Incontinence**
  - **□ Pain management**
  - **□ Medication / polypharmacy**
  - **□ Sleep**
  - **□ Weight loss / nutrition**
- **□ Cognitive / Behavioural** → **□**
  - **□ Memory Loss**
  - **□ Dementia diagnosis clarification**
  - **□ Delusions /hallucinations**
  - **□ Depression**
  - **□ Wandering**
  - **□ Verbal / physical aggression**
- **□ Psychosocial** → **□**
  - **□ Caregiver / family issues**
  - **□ Elder abuse**
  - **□ Social isolation**
- **□ Functional** → **□**
  - **□ ADL/IADL decline**
  - **□Home safety concern**
  - **□ Other** *(specify)*: _____

MEDICAL INFORMATION
Main Concern(s) to be addressed:

Type text here

Medical History □ Attach health summary report

Type text here

Medication History □ Medication list attached

Type text here

Urgency of Referral

□ Routine Assessment

□ *Urgent*
(select risk factors):

- □ Recurrent ED visits
- □ Caregiver burnout
- □ Atypical cognitive changes (cause unclear)
- □ Recent acute decline as indicated in reason for referral

Name of Family MD: _____ **Tel #** _____ **Fax #** _____

Referring Organization: _____ **Tel #** _____

Name of Referring Physician _____ **Tel #** _____ **Fax #** _____

Signature of Referral Physician _____ **Billing #** _____ Date: _____

Services Requested: Geriatric Medicine Consultation

Hospital Requested: **Toronto Grace Health Centre**
Fax # 647-689-3554

Consultant Requested:
- □ Dr. Arielle Berger
- □ Dr. Marly Isen
- □ First available