HUMBER RIVER HOSPITAL

Geriatric Outreach Referral Form

RGP

Name of Client: _____ Birth Date: _____ □ **M** □ **F**

Address: _____ ON Postal Code: _____

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

Health Card #: _____ Version Code: _____ Language Spoken: _____

Contact Person: _____ Relationship: _____ Phone #: _____

Is Client/Substitute decision maker agreeable to referral? □ **Yes** □ **No**

INSTRUCTIONS: Please indicate reason(s) for referral and complete the medical information section below.

NOTE: While the HRH Geriatric Outreach Team does not require a physician's referral, a physician's signature will aid in transferring a client that resides outside our catchment area.

REASON FOR REFERRAL	**MEDICAL INFORMATION:** Main concern(s)
□ ADLs/IADLs	
□ Behavioural difficulties	
□ Cognition/Dementia	
□ Delirium	
□ Delusions/Hallucinations	
□ Depression/Anxiety	
□ Foot problems	
□ Home safety	
□ Incontinence	
□ Medications	
□ Mobility/Falls	
□ Caregiver/Family issues	
□ Social Isolation/Lives alone	
□ Verbal/Physical aggression	
□ Wandering	
□ Weight loss/Nutrition	

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

Referring professional (print): _____ **Phone #** _____

Fax # _____ **Signature of Referring Physician:** _____

Phone #: 416-242-1000, ext. 21817/21818
PLEASE FAX TO 416-242-1108, ALONG WITH RELATED CONSULTATION NOTES AND/OR RECENT LAB/DIAGNOSTIC RESULTS

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