Providence Care

PERSONAL HEALTH INFORMATION

GERIATRIC MEDICINE CLINIC REFERRAL FORM

Fax referral to Providence Care Central Intake 613-548-5595

Please note an incomplete referral form and missing documentation will result in requests for additional information and a delay in processing your referral.

PATIENT/CLIENT DEMOGRAPHICS	RELATIONSHIP TO CLIENT/PATIENT
NAME ☐ M ☐ F	Living Arrangement ☐ With spouse ☐ Alone ☐ Other
Address	Next of Kin/Primary Contact
Telephone (Home)	Relationship to Client
Date of Birth	Telephone (Home)
Health Card #	Telephone (Other)

French Language Services Required? ☐ Yes ☐ No	TO BE COMPLETED BY PROVIDENCE CARE STAFF **Interpreter** ☐ Family ☐ Professional ☐ Staff ☐ Volunteer **Format** ☐ Written ☐ Verbal ☐ Both

REFERRAL INFORMATION ***(the following is to be filled in by the physician or nurse)***

Referral Source: *(e.g. family physician, team nurse, CCAC)*	Telephone:	Fax:

IS FAMILY PHYSICIAN AWARE OF THIS REFERRAL? ☐ **Yes** ☐ **No**

(If the family physician ***has not been made aware of the referral****, please be advised it is part of Specialized Geriatrics practice to do so.)*

Family Physician Name _____ **Telephone** _____ **Fax #** _____

Address _____

Reason for Referral:

Please provide any additional information that will be relevant to our assessment and the care of your patient.

Are there **OTHER GERIATRIC ISSUES?**

☐ Multiple medical concerns ☐ Cognition ☐ Falls ☐ Medications ☐ Depressed mood ☐ Caregiver stress
☐ Urinary incontinence ☐ Driving ☐ Safety concerns

Signature:	☐ MD ☐ RN(EC)	Date

(If at all possible, please provide MD or RN(EC) signature.)

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SPECIALIZED GERIATRICS

CONTINENCE CLINIC

Referral Criteria: Patients over 75 years of age with urinary incontinence issues.

Type of Service: Provides inter-professional assessment, diagnosis and treatment for elderly patients with urinary incontinence issues.

GERIATRIC MEDICINE CLINIC

Referral Criteria: High risk, frail elderly patients with multiple co-morbidities as well as memory and/or cognition issues.

Type of Service: Provides inter-professional assessment, diagnosis and stabilization to frail elderly patients and family.

MEMORY CLINIC

Referral Criteria: Individuals over 50 years of age with new onset memory and/or cognition issues not related to ABI or Psychiatric diagnoses.

Type of Service: Provides inter-professional assessment, diagnosis and recommendations for patients with memory and/or cognitive disorders.