Providence Care

PERSONAL HEALTH INFORMATION

GERIATRIC MEDICINE
OUTPATIENT REFERRAL

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

☐ Geriatric Medicine/Seniors Rehabilitation ☐ Memory Disorder Clinic

PATIENT/CLIENT DEMOGRAPHICS	**RELATIONSHIP TO CLIENT/PATIENT**
Name	Living Arrangement ☐ With spouse ☐ Alone ☐ Other:
Address	Next of Kin/Primary Contact
Telephone (Home)	Relationship to Client
Date of Birth YYYY/MM/DD	Telephone (Home)
Gender	Telephone (Other)
French Language Services Required? ☐ Yes ☐ No ☐ Other: _____	
REFERRAL INFORMATION (the following is to be filled in by the physician or nurse)	
Referral Source: _____ Telephone: _____ Fax: _____	
Family Physician Name: _____ Telephone: _____ Fax: _____ Address: _____	
THIS REFERRAL WILL NOT BE CONSIDERED ACTIVE UNTIL ALL REQUESTED INFORMATION HAS BEEN RECEIVED Please provide all information that will be relevant to our assessment and the care of your patient. (This must include a current list of medications/relevant, Past Medical History, recent labs and x-ray's). If any urgency please indicate why and timeline).	
REASON FOR REFERRAL	
To be completed by Referring Physician or Nurse	
Date: YYYY/MM/DD Print Name: _____ ☐ MD Time: HH:MM Signature: _____ ☐ RN (EC)	