

Name of Client: _____ M F Other
Surname First Name

Address: _____ Ontario
Street Name and Number City Province Postal Code

Telephone #: _____ Lives Alone? Y N Marital Status: _____

Health Card #: _____ Version Code _____ Date of Birth _____
dd/mm/yyyy

Alternate Contact _____ Relationship _____ Telephone #: _____

Patient or Substitute Decision Maker (if patient incapable) has given consent for this referral: Y N Unknown

Pref.'d Language English French Other: _____

Is patient currently in hospital? Y N Planned discharge date: _____

Home & Community Care involved? Y N Unknown Previous SGS Consult/referral? Y N Unknown

Current Challenges (Check all that apply)

- Cognitive/Behavioral
 - Delirium
 - Anxiety
 - Verbal/physical aggression
 - Cognition/dementia
 - Delusions/hallucinations
 - Depression
 - Wandering
 - Suspicious behaviour
- Psychosocial
 - Caregiver/family issues
 - Elder abuse
 - Social isolation
- Functional ADL/IADL decline
 - Driving safety
 - Home safety
- Other (please specify):

What I am seeking for my patient from the consultation

- Determine diagnosis
- Confirm/review existing diagnosis
- Medication review to improve identified symptoms
- Responsive behaviour management
- Fall prevention management
- Living independence evaluation/recommendations
- Driving competence evaluation/recommendations

Please enter/include further pertinent information (eg. Previous medications/treatments explored)

Name of Family MD _____ Telephone # _____ Fax #: _____

Name of Referring Physician _____ Telephone # _____ Fax #: _____

Primary Care Provider in agreement with Referral to SGS? Y N Billing Number: _____

Signature of Referral Physician (if applicable) _____ Date: _____

**** Referrals will not be accepted without a Family MD to implement recommendations. If there is no Family MD, call RCVTAC to initiate referral 1 (844) 727-6404 ****