SPECIALIZED GERIATRIC SERVICES(SGS)
COMMON REFERRAL FORM
TEL: (613) 735-6500 1-877-260-0535 Central Intake FAX: (613) 735-4638

Name of Client: _____ _____ ☐ **M** ☐ **F**
Surname *First Name*

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 #:** _____

Patient or Substitute Decision Maker (if patient incapable) has given consent for this referral: ☐**Yes** ☐**No** ☐**Unsure**

Preferred Language: ☐ **English** ☐ **French** ☐**Other** _____

Is patient currently in Hospital? ☐ **Yes** ☐ **No** **Planned discharge date** _____

Home & Community Care involved? ☐**Yes** ☐**No** ☐**Unsure**

CURRENT CHALLENGES *(Check all that apply)*

☐ **Medical / Physical**
- ☐ **Mobility**
- ☐ **Falls**
- ☐ **Incontinence**
- ☐ **Pain management**
- ☐ **Medication / polypharmacy**
- ☐ **Sleep**
- ☐ **Weight loss / nutrition**
- ☐ **Frequent ER visits**

☐ **Cognitive / Behavioral**
- ☐ **Delirium**
- ☐ **Anxiety**
- ☐ **Verbal / physical aggression**
- ☐ **Cognition / dementia**
- ☐ **Delusions / hallucinations**
- ☐ **Depression**
- ☐ **Wandering**
- ☐ **Suspicious behavior**

☐ **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 Behavior 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: _____ **Tel #** _____ **Fax #** _____

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

Primary Care Provider in agreement with Referral to SGS ☐ **Yes**

Signature of Referral Physician *(if applicable)* _____ **Billing #** _____ Date: _____

(Dec 2019 version 7)