

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 <i>(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.)</i>			
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.)

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 55 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.