GREY BRUCE SPECIALIZED GERIATRIC SERVICES REFERRAL FORM

PHONE: 519-376-2121, ext. 2436 **FAX**: 519-378-1478

The patient's personal health information may be shared with any of the providers of specialized geriatric services in Grey Bruce to determine the appropriate service:

- Behavioural Supports Ontario (BSO) Team at Grey Bruce Health Services
- Geriatric Resource Nurses (GRNs) employed by St. Joseph's Health Care London
- Geriatricians at Grey Bruce Health Services & Listowel Wingham Hospitals Alliance

PATIENT INFORMATION

Last name	First name	Gender:
Address:	Phone Number 1: Phone number 2:	Language:
Health card (including version code)	Date of birth: YYYY/MM/DD	**Person to contact:** ☐ Patient ☐ Alternate contact

ALTERNATE CONTACT

Name	Relationship to patient	Phone number:

REASONS FOR REFERRAL (check all that apply)

- ☐ Frailty
- ☐ Functional decline
- ☐ Complex medical history
- ☐ Recurrent hospitalizations, ED visits
- ☐ Medication review/polypharmacy
- ☐ Mobility and falls
- ☐ Movement disorders (e.g. Parkinsonism)
- ☐ Driving concerns
- ☐ Cognition/personality changes
- ☐ Caregiver support and education
- ☐ Safety concerns **(specify):**

- ☐ Home visit required **(specify why):**
- ☐ Responsive behaviours due to **diagnosed** Dementia, Mental Illness, Addictions **(specify):**
- ☐ Mood, mental health, or addictions **(specify):**
- ☐ Other **(specify):**

HISTORY OF PRESENTING ILLNESS

Please attach **if available**:

- Patient profile with health history and medication list
- Record of initial work-up (eg. relevant labs, imaging, mood screening, memory assessment)

REFERRAL SOURCE

Name (PRINT): Organization: Contact #: **Primary Care Provider** (if not referrer)**:** Associated with Primary Care Organization: (eg. FHT, FHO)? specify:	Physician/Nurse Practitioner SIGNATURE (not required for BSO service) x_____ If verbal order, taken by: Office Address: Phone: Fax: Billing number: Date of Referral: YYYY/MM/DD