GREY BRUCE GERIATRIC SERVICES INTEGRATED 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 listed to determine the most appropriate ambulatory geriatric service in accordance with the *Personal Health Information Protection Act* (PHIPA):

- Behavioural Supports Ontario (BSO) Team at Brightshores Health System
- Geriatric Resource Nurses (GRNs) employed by St. Joseph's Health Care London
- Geriatricians at Brightshores Health System

PATIENT INFORMATION

Last name	First name	Gender:	Has Patient/SDM consented to this referral? ☐Yes ☐ No
Address:	Phone Number 1: Phone Number 2:		Preferred Language:
Health card (including version code)	Date of birth: YYYY/MM/DD		**Person to contact about referral:** ☐ Patient ☐ Alternate contact

ALTERNATE CONTACT

Name	Relationship to patient	Phone number:

REASONS FOR REFERRAL (check all that apply)

☐ Cognitive concerns
☐ Personality changes
☐ Mood (depression, anxiety)
☐ Mobility evaluation, recurrent falls
☐ Osteoporosis, fractures
☐ Complex medical history
☐ Frailty, functional decline
☐ Recurrent hospitalizations, ED visits
☐ Medication review/polypharmacy
☐ Driving concerns

☐ Safety concerns **(please specify):**

☐ Home visit required **(please specify why):**

☐ Responsive behaviours due to **diagnosed** dementia, mental health and/or addictions? ☐ Yes ☐ No
Current diagnosis:________________________________
If yes, please outline specific behavioural concerns:

PRIMARY REASON FOR REFERRAL (main clinical question/concern, presenting illness/diagnosis):

Has the patient had a local memory clinic assessment? ☐ Yes (*Please attach clinic notes and testing*) ☐ No

Please ensure and attach for <u>timely review of referral</u>:
☐ Patient profile with health history and medication list
☐ Updated geriatric screening lab work: CBC, electrolytes (including bicarbonate, Mg, Phos, Ca), BUN, Creatinine, ALT, TSH, B12, Urinalysis & culture
☐ Head imaging (PLEASE ORDER if not completed in past 2 years)
☐ Any relevant notes including past memory clinic notes, cognitive/mood testing, if available

REFERRAL SOURCE

Name (PRINT):

Organization:

Contact #:

Primary Care Provider (if not referrer)**:**

Primary Care Team Affiliation (FHT, FHO, CHC):
Please 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	

The Intake and access of referrals is completed by Grey Bruce Geriatric Services. We work in partnership with the GERIATRIC AMBULATORY ACCESS TEAM (GAAT) at St. Joseph's Health Care London for regional geriatric services not provided locally. If your patient requires a regional service, your referral will automatically be forwarded to GAAT by Grey Bruce Geriatric Services.