REGIONAL GERIATRIC ASSESSMENT PROGRAM (RGAP)
GERIATRIC ASSESSMENT OUTREACH TEAM (GAOT) INTAKE FORM

EAST ☐ SCOHS Elizabeth Bruyère
Tel. (613) 562-6362 Fax (613) 562-6373

WEST ☐ Queensway-Carleton Hospital
Tel (613) 721-0041 Fax (613) 820-6659

PATIENT INFORMATION:

SURNAME ☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Dr.	GIVEN NAME	DOB (yy/mm/dd)	AGE	SEX ☐ Female ☐ Male

ADDRESS	CITY	PROV	POSTAL CODE	PHONE #

ONTARIO HEALTH CARD #	VERSION CODE:	PREFERRED LANGUAGE: ☐ ENGLISH ☐ FRENCH	OTHER (Specify)	MOTHER TONGUE

CLIENT AGREED TO REFERRAL? ☐ NO ☐ YES IF NO, WHY?

FAMILY PHYSICIAN REFERRAL SOURCE:

FAMILY PHYSICIAN:

ADDRESS	CITY	PROV	POSTAL CODE	PHONE #

OTHER REFERRAL SOURCE (PLEASE COMPLETE FAMILY PHYSICIAN SECTION):

AGENCY/PROFESSIONAL/RELATIONSHIP TO CLIENT:

FAMILY DR. AWARE OF REFERRAL? ☐ NO ☐ YES IF NO, WHY?

FAMILY DR. AGREED TO REFERRAL? ☐ NO ☐ YES IF NO, WHY?

ADDRESS	CITY	PROV	POSTAL CODE	PHONE #

REASON FOR REFERRAL (S) (PLEASE CHECK ALL THAT APPLY):

☐ Cognitive Assessment ☐ Mood Assessment	☐ Functional Assessment ☐ Behaviour problems	☐ Medication Review / Management ☐ Multiple medical problems	☐ Caregiver Stress ☐ Risk	☐ Mobility

Comments:

SIGNIFICANT MEDICAL HISTORY (INCLUDING RECENT CHANGES):

1.	2.	3.
4.	5.	6.

CAREGIVER INFORMATION:

Name	Relationship		Telephone: Home: Office: Cell:
Address	City	Province	Postal Code

WHO SHOULD BE CONTACTED FOR APPOINTMENT? ☐CLIENT ☐CAREGIVER ☐BOTH

PREVIOUS CONTACT WITH REGIONAL GERIATRIC ASSESSMENT/TREATMENT SERVICES/GERIATRIC PSYCHIATRY SERVICES/MEMORY DISORDER CLINIC:

DATES AND SERVICE (S):

RGAP SERVICES:	GAOT ☐EAST ☐WEST	Geriatric Day Hospital ☐CIVIC ☐QCH ☐EB	Clinic: ☐YES ☐NO Location:	In-patient GAU: ☐CIVIC ☐QCH

OTHER SERVICES:	Geriatric Psychiatry Community Services: ☐	ROH ☐	Memory Disorder Clinic ☐

LIST OTHER SPECIALISTS CURRENTLY INVOLVED:

Cardiology☐	Neurology ☐	Urology ☐	Ortho ☐	In-patient GAU ☐
Rheumatology ☐	GI ☐		Other: ☐ ____________________ NAME: ____________________ ☐ ____________________ NAME: ____________________	

ARE PROFESSIONAL OR COMMUNITY SERVICES INVOLVED? Please list contact name and phone number, if known.

CCAC: Case Manager:	Nursing	Homemaking	M.O.W	Helpline
Private	Para-Transpo		Other	

ANY KNOWN SAFETY CONCERNS FOR VISITORS COMING INTO THE CLIENT"S HOME?

☐ Aggressive physical behaviour ☐ Potential litigation concerns	☐ Aggressive verbal behaviour ☐ Caregiver/Family behaviour	☐ Environmental conditions ☐ Health Issues	☐ Pets ☐ Other:

ADDITIONAL COMMENTS: (Please attach a sheet if additional space is required.)

Completed by: (please print name)	Signature
Agency Affiliated With:	Referral Date: (yy-mm-dd)