



**REGIONAL GERIATRIC PROGRAM OF EASTERN ONTARIO (RGPEO)  
GERIATRIC ASSESSMENT OUTREACH TEAM (GAOT) INTAKE FORM**

**EAST**  Bruyère Continuing Care  
Tel. (613) 562-6362 Fax (613) 562-6373

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

Does the patient live alone?  NO  YES

<b>PATIENT INFORMATION:</b>						
SURNAME <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.		GIVEN NAME		DOB (yy/mm/dd)	AGE	SEX <input type="checkbox"/> Female <input type="checkbox"/> Male
ADDRESS			CITY	PROV	POSTAL CODE	PHONE #
ONTARIO HEALTH CARD #	VERSION CODE:	PREFERRED LANGUAGE: <input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH		OTHER (Specify)	MOTHER TONGUE	
CLIENT AGREED TO REFERRAL? <input type="checkbox"/> NO <input type="checkbox"/> YES IF NO, WHY?						
<b>FAMILY PHYSICIAN REFERRAL SOURCE:</b>						
FAMILY PHYSICIAN:						
ADDRESS			CITY	PROV	POSTAL CODE	PHONE #
<b>OTHER REFERRAL SOURCE (PLEASE COMPLETE SECTION BELOW AS WELL AS FAMILY PHYSICIAN SECTION):</b>						
AGENCY/PROFESSIONAL/RELATIONSHIP TO CLIENT:						
ADDRESS			CITY	PROV	POSTAL CODE	PHONE #
FAMILY DR. AWARE OF REFERRAL? <input type="checkbox"/> NO <input type="checkbox"/> YES IF NO, WHY?				FAMILY DR. AGREED TO REFERRAL? <input type="checkbox"/> NO <input type="checkbox"/> YES IF NO, WHY?		
<b>REASON FOR REFERRAL (S) (PLEASE CHECK ALL THAT APPLY):</b>						
<input type="checkbox"/> Cognition	<input type="checkbox"/> Functional	<input type="checkbox"/> Medication Review / Management	<input type="checkbox"/> Caregiver Stress	<input type="checkbox"/> Difficulty with Transfers/Mobility		
<input type="checkbox"/> Mood	<input type="checkbox"/> Behaviour problems	<input type="checkbox"/> Multiple medical problems	<input type="checkbox"/> Risk/Safety Concerns			
<input type="checkbox"/> Falls, Number of:	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Nutritional Concerns	<input type="checkbox"/> Other:			
<input type="checkbox"/> Pain						
Comments:						
<b>SIGNIFICANT MEDICAL HISTORY (INCLUDING RECENT CHANGES):</b>						
1.		2.		3.		
4.		5.		6.		
<b>CAREGIVER INFORMATION:</b>						
Name		Relationship			Telephone: Home: Office: Cell:	
Address		City		Province	Postal Code	
WHO SHOULD BE CONTACTED FOR APPOINTMENT? <input type="checkbox"/> CLIENT <input type="checkbox"/> CAREGIVER <input type="checkbox"/> BOTH						

**PLEASE COMPLETE REVERSE SIDE**

<b>PREVIOUS CONTACT WITH REGIONAL GERIATRIC PROGRAM/TREATMENT SERVICES/GERIATRIC PSYCHIATRY SERVICES/MEMORY DISORDER CLINIC:</b>				
DATES AND SERVICE (S):				
<b>RGP SERVICES:</b>	GAOT <input type="checkbox"/> EAST <input type="checkbox"/> WEST	Geriatric Day Hospital <input type="checkbox"/> CIVIC <input type="checkbox"/> QCH <input type="checkbox"/> Bruyere	Clinic: <input type="checkbox"/> YES <input type="checkbox"/> NO Location:	In-patient GAU: <input type="checkbox"/> CIVIC <input type="checkbox"/> QCH <input type="checkbox"/> Geriatric Rehab - Bruyere
<b>OTHER SERVICES:</b>	<input type="checkbox"/> Geriatric Psychiatry Community Services of Ottawa	<input type="checkbox"/> Royal Ottawa Health Care Group	<input type="checkbox"/> Memory Disorder Clinic	
<b>LIST BY NAME OTHER SPECIALISTS CURRENTLY INVOLVED IN YOUR CARE:</b>				
<input type="checkbox"/> Cardiology	<input type="checkbox"/> Neurology	<input type="checkbox"/> Urology	<input type="checkbox"/> Ortho	<input type="checkbox"/> Rheumatology
<input type="checkbox"/> GI	Other: <input type="checkbox"/> _____ NAME: _____ <input type="checkbox"/> _____ NAME: _____			
<b>ARE PROFESSIONAL OR COMMUNITY SERVICES INVOLVED? Please list contact name and phone number, if known.</b>				
CCAC: Case Manager:	Nursing	Homemaking	M.O.W	Helpline
Private	Para-Transpo		Other	
<b>ANY KNOWN SAFETY CONCERNS FOR VISITORS COMING INTO THE CLIENT'S HOME?</b>				
<input type="checkbox"/> Aggressive physical behaviour <input type="checkbox"/> Potential litigation concerns	<input type="checkbox"/> Aggressive verbal behaviour <input type="checkbox"/> Caregiver/Family behaviour	<input type="checkbox"/> Environmental conditions <input type="checkbox"/> Health Issues <input type="checkbox"/> MRSA/VRE (Positive Y/N)	<input type="checkbox"/> Pets <input type="checkbox"/> Other:	
<b>ADDITIONAL COMMENTS: (Please attach a sheet if additional space is required.)</b>				
<b>COMPLETED BY:</b>				
Completed by: (please print name)			Signature	
Agency Affiliated With (Please indicate unit/floor if from a hospital):			Referral Date: (yy-mm-dd)	