Regional Geriatric Program of Eastern Ontario
Programme gériatrique régional de l'Est de l'Ontario

CENTRAL INTAKE
SPECIALIZED GERIATRIC SERVICES (GERIATRIC MEDICINE)

Phone: 613-761-4145 Fax: 613-761-5388

Date:

KEY INFORMATION

- **Client will be triaged to the most appropriate service based on current geriatric issues, wait times and urgency**
- **If your primary concern is related to mental health or behaviour associated with dementia, please refer to Geriatric Psychiatry Central Intake (Phone: 613-562-9777 or Fax: 613-562-0259)**

Client is aware, agreeable and consents to referral and sharing of information? ❑ Yes If No, unable to proceed with referral

CLIENT INFORMATION

Last Name:	First Name:	Sex: ❑ M ❑ F	DOB:	Age:
Address:	City:		Postal Code:	
Phone:	Ontario Health Card:		Language: ❑ E ❑ F ❑ Other:	

REASONS FOR REFERRAL

❑ Cognition – if previously assessed, indicate date and location: _____	❑ Medication Review	❑ Other:
❑ Falls	❑ Polypharmacy	
❑ Function	❑ Deprescribing	
❑ Mobility	❑ Nutrition	
❑ Mood	❑ Caregiver Stress	
	❑ Driving	
	❑ Risk/Safety Concerns	

ALTERNATE CONTACT INFORMATION

Name:	Relationship to client:	Contact Number:

Please contact: ❑ Client ❑ Alternate Contact

PRIMARY CARE PROVIDER **SIGNATURE AND BILLING NUMBER:**

Name:	Phone:	Fax:

REFERRAL SOURCE ❑ PRIMARY CARE PROVIDER AS ABOVE

Name:	Referring Service:	Phone:	Fax:

MEDICAL HISTORY

Please attach recent blood work (≤3 months), diagnostic imaging (within the last 2 years) and relevant consultations.

ADDITIONAL INFORMATION INCLUDING GOALS AND EXPECTATIONS:

PROGRAM PREFERENCE: ❑ **Geriatric Day Hospital** ❑ **Geriatric Assessment Outreach Team** (home visit)
❑ **GeriMedRisk** (Telephone/e-consult service for complex cases requiring geriatric psychiatry and/or clinical pharmacology support)