CENTRAL INTAKE
SPECIALIZED GERIATRIC SERVICES

Phone: 613-761-4145 Fax: 613-774-7240

Referral Date:

CLIENT INFORMATION (APPLY CLIENT LABEL IF AVAILABLE)

Client's Last name:	First Name:	Sex: ☐M ☐F	DOB: (yyyy/mm/dd)	Age:
Street address:		City:	Postal Code:	
Phone:	Ontario Health Card:	Version Code:	Preferred Language: ☐E ☐F ☐Other:	

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

ALTERNATE CONTACT INFORMATION

Name:	Relationship to client:	Home Phone:	Work Phone:	Cell Phone:

Please contact: ☐Client ☐Alternate Contact

PRIMARY CARE PROVIDER

Name: (and Billing Number)	Phone:	Fax:

REFERRAL SOURCE ☐PRIMARY CARE PROVIDER AS ABOVE

Name: (& Billing Number if applicable)	Referring Service	Phone:	Fax:

REASONS FOR REFERRAL (Please check all that apply)

☐Cognition – if previously assessed, indicate date and location: ☐Falls # of: **0** ☐Function ☐Mobility	☐Medication Review ☐Mood ☐Nutrition ☐Caregiver Stress ☐Driving	☐Risk/Safety Concerns ☐Other: Please specify

SIGNIFICANT MEDICAL HISTORY (including recent changes) ☐**Attached**

Please attach the Cumulative Patient Profile, pertinent and recent blood work, diagnostic imaging and medical history. This will expedite the triage process.

ADDITIONAL INFORMATION:
Please include Goals and Expectations

If you have a SGS preference, please indicate:

☐Geriatric Day Hospital
☐Geriatric Assessment Outreach Team (GAOT)
☐GeriMedRisk

Soins continus Bruyère Continuing Care | The Ottawa Hospital | L'Hôpital d'Ottawa | Regional Geriatric Program of Eastern Ontario / Programme gériatrique régional de l'Est de l'Ontario | GERIMEDRISK | Queensway Carleton Hospital