RENFREW COUNTY SPECIALIZED GERIATRIC SERVICES REFERRAL FORM

In partnership with the, Pembroke Regional Hospital, the Ottawa Hospital
Champlain Community Care Access Centre
and Royal Ottawa Health Care Group.

TEL: (613) 732-8770 EXT: 6500 FAX: (613) 735-4638

DATE OF REFERRAL:____________________________________

Name of Client ____ ☐M ☐F
Surname first name

Address ____
Street Name and Number Apartment City Prov. Postal Code

Phone# (_______)_________-_______________ **Marital Status** ________________ **DOB** ______________________________

Health Card # ______________________________**VER** ____________ **Language: E - ☐ F - ☐ Other** _______________

Contact Person ______________________________ **Relationship** _______________________ **Phone #** ________________
daytime number

Contact Address ___________________________ **Client/Power of Attorney (POA) consent to referral** ☐ **Yes** ☐ **No**

CURRENT STATUS: ☐ Home ☐ Hospital/Date:____
(ADMISSION DATE / NAME)

☐ Retirement Home/Date: _______________________________ ☐ Long Term Care/Date:________________________________
(ADMISSION DATE / FACILITY NAME) (ADMISSION DATE / FACILITY NAME)

REASONS FOR REFERRAL: (Please fax related Consultations and/or Labs / Tests)

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MEDICAL DIAGNOSIS:

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Allergies____

Previous psychiatric/geriatrician Consults? Date:____________________Psychiatrist/Geriatrician:______________________________

- ☐ Mild Dementia
- ☐ Moderate to Severe Dementia
- ☐ Behavioural difficulties
- ☐ Suspicious Behaviour
- ☐ Delusions / hallucinations
- ☐ Verbal/physical aggression
- ☐ Depression/anxiety/mania
- ☐ Failure to thrive
- ☐ Wandering
- ☐ Disinhibition
- ☐ Weight loss/nutrition
- ☐ Sleep Disturbances
- ☐ Medication Review
- ☐ Mobility/falls
- ☐ Home safety
- ☐ ADL/IADL concerns
- ☐ Frequent ER visits / Hospitalizations
- ☐ Incontinence
- ☐ Other________________

Name of Referring MD ***(please print)***____ **Phone #** ________________

Name of Family MD ***(if different from referring MD)***____________________________ **Phone #** ________________

Signature of MD ____ **Date *(d/m/y)***_____________

June 2014