

Aging Well Clinic

Geriatrics Referral

Health Record #: _____	Complete or place barcoded patient label here
Patient Name: (Print first, last) _____	
DOB: <u>dd</u> / <u>mm</u> / <u>yy</u>	Age: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male
OHIP #: _____	Version Code: _____
Account #: _____	Date of Admission: <u>dd</u> / <u>mm</u> / <u>yy</u>

Fax completed forms to: 905-952-2453

Service Description & Referral Criteria

The Aging Well Clinic (AWC) offers geriatric consultation for older adults experiencing functional decline (cognitive and/or physical). **This service is not intended for ongoing monitoring or long-term follow up. Ongoing medical care is the responsibility of the Primary Care provider.** Referrals are triaged and assigned to the most suitable service (Geriatrician, Nurse Practitioner or Geriatric Outreach).

The AWC is not a crisis or emergency service. Wait time varies from weeks to several months based on the clinic's assessment of clinical urgency based on the information provided within the referral form. Acute conditions (neurological, cardiac, gastrointestinal, etc.) should be evaluated by an emergent and/or rapid access service.

Patients must meet the referral criteria listed below:

- 65 years of age or older; or evidence of a geriatric syndrome if less than 65
- Lives within the Southlake Health catchment area or is referred by a Southlake specialist
- Not under the care of a Geriatrician

Exclusion Criteria:

- Capacity assessments
- Medico-legal assessments
- Long term care residency
- Principle concern related to mental illness (consider referral to LOFT Community Services: Integrated Psycho-Geriatric Outreach Program - IPOP. For eligibility criteria and to access referral form, please call LOFT BSO Central Access 1-844-798-6920).

Incomplete and/or out of catchment referrals will be returned.

Patient Information:

Patient Name: (print first, last)

Address:	Street Number + Name	Apartment
	City	Province
		Postal Code
Health Card Number:	Version Code:	Date of Birth: <u>dd</u> / <u>mm</u> / <u>yy</u>
Patient Phone #: ()	Marital Status:	Gender:

Scheduling Information:

- AWC to book the appointment directly with the patient AWC to book the appointment with an alternate contact

Name:	
Relation:	Contact Number: ()
Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	Language:



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Referral Information: (please provide as much information as possible to support the referral)

Will a geriatric opinion inform imminent treatment and/or care planning? Yes No *Details:*

Is the patient homebound? Yes No

Does the patient live alone? Yes No

Medical/Physical/Functional

- Difficulty with ADLs
- Difficulty with IADLs
- Driving Safety
- Home Safety
- Incontinence
- Medication/Polypharmacy
- Mobility/Falls
- Sleep Disturbance
- Weight Loss

Cognitive/Behavioural

- Cognitive impairment
- Behavioural and Psychological Symptoms of Dementia (BPSD):
 - Agitation
 - Delusions/Hallucinations
 - Verbal/Physical Aggression
 - Wandering
 - Other (please describe above)

Psychosocial

- Caregiver/Family Stress
- Social Isolation/Loneliness
- Future Planning

Past Medical History:

Please attach the following information (unless accessible on Connecting Ontario/Meditech):

- Past medical history
- Medication list
- Test results completed within last 12 months (e.g. cognitive scores, blood work, 12 lead ECG)
- Relevant consultation reports (e.g. Cardiology, Neurology, Geriatrics, Psychiatry)

Geriatric consultation requires the following investigations & diagnostics:

• **Head Imaging (CT or MRI) within the last 12 months**

Available and/or attached Yes No
 If not available, ordered: Yes
 Date ordered: dd / mm / yy

• **Blood Work within the last 12 months**
(CBC, Lytes, Ca, Mg, LFTs, B12, TSH, Hgb, A1C, Ferritin)

Available and/or attached Yes No
 If not available, ordered: Yes
 Date ordered: dd / mm / yy

• **ECG within the last 12 months**

Available and/or attached Yes No
 If not available, ordered: Yes
 Date ordered: dd / mm / yy

Access to these diagnostics allows us to maximize the value of the patient's geriatric appointment.

Consent for Referral Obtained From: Patient SDM/POA **Date:** dd / mm / yy

Referring Provider: (print first, last)

Signature of Referring Provider:

Billing #:

Phone Number: ()

Fax Number: ()

Primary Provider if not Referring Provider: (print first, last)

Phone Number: ()

Fax Number: ()

