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| **Required Referral Form to Access NBRHC’s Nipissing Specialized Geriatric Services** |
| If you have a preferred service, please check the appropriate box (*optional*): |
|[ ]  **Seniors’ Mental Health**  |[ ]  **Geriatric Medicine Clinic** |[ ]  **Behavioural Supports Ontario** |
| *All information will be considered during the intake process and referrals will be triaged to the most appropriate service(s).* |
| **Patient Demographics** |
| Name *(last, first*): |  | DOB (*dd/mm/yyyy*): |  |
| Gender: |  | Health Card #: |  | Version Code: |  |
| Preferred Language: |  |
| Address (*unit/street #)*: |  |
| City: |  |  Postal Code: |  | Phone #: |  |
| Lives alone: [ ]  No [ ]  Yes  | If no, please specify:  |  |
| Secondary Contact: |  |
| Relationship: |  | Phone #: |  |
| Did patient/SDM consent to this referral? [ ]  No [ ]  Yes | Comments:  |  |
| **Person to Contact Regarding this Referral** |
|[ ]  Patient  |[ ]  Secondary Contact | [ ]  Other (*if other, please specify below)* |
| Name: |  | Relationship: |  | Phone #: |  |
| **Agency Involvement** |
|[ ]  Home & Community Care |[ ]  Mental Health Services |
|[ ]  Alzheimer Society |[ ]  North East Specialized Geriatric Centre |
|[ ]  Other (*please specify*):  |  |
| **Reason for Referral** |
|[ ]  Cognitive changes |[ ]  Mobility/falls |
|[ ]  Behavioural changes |[ ]  Functional changes |
|[ ]  Mood symptoms |[ ]  Incontinence |
|[ ]  Symptoms of psychosis |[ ]  Pain management |
|[ ]  Suicidal/homicidal ideation |[ ]  Sleep disturbance |
|[ ]  Substance/Medication misuse |[ ]  Unintended changes in weight/nutrition |
|[ ]  Polypharmacy/Medication Review |[ ]  Complex medical problems |
|[ ]  Caregiver/family concerns | [ ]  | Multiple ED visits secondary to geriatric syndromes |
|[ ]  Social isolation |  |  |
|[ ]  Other (*please specify*): |  |
| **Brief Description and Clinical Question** |
|  |
| **Legal Concerns** |
| Are there any legal concerns (consent, capacity, abuse, etc.)? [ ]  No [ ]  Yes |
| If yes, please specify: |  |
| Has a MTO report been completed? [ ]  No [ ]  Yes |
| **Risks and/or Safety Concerns (*for patient and others*)** |
|  |
| **Relevant Medical, Surgical & Psychiatric History –** *Please attach any relevant clinical information from your EMR (e.g. notes from recent visits, consult notes) that would not already be available in Connecting Ontario.* |
|   |
| **Current Medications**  |
|[ ]  Please attach Medication list/CPP |
| **Allergies** |
|  |
| **Required Investigations for Seniors’ Mental Health and Geriatric Medicine Clinic Referrals***Please ensure the following recent (within the last 3 months) results are available:* |
|[ ]  CBC |[ ]  TSH, B12 |
|[ ]  HbA1c |[ ]  ECG |
|[ ]  Creatinine, eGFR |[ ]  VDRL (if risk factors)  |
|[ ]  Electrolytes and calcium, albumin, magnesium, and phosphorus |[ ]  Serum Drug Levels (e.g. lithium or other mood stabilizers, anticonvulsants, digoxin) if applicable |
|[ ]  CT/MRI scan results (required for referrals related to cognitive changes) |[ ]  Completed cognitive screening assessments if available (e.g. MMSE/MoCA) |
| **Additional Comments** |
|  |
| **Primary Care Provider:** |
| Print Name: |  |
| Phone #: |  | Fax # (*if applicable*): |  |
| **Request for Referral Initiated by (*please specify):*** |
| [ ]  Family | [ ]  Patient |
| [ ]  Primary Care Provider | [ ]  Other: |  |
| **Referring Physician/Nurse Practitioner (*if different than PCP*):** |
| Print Name: |  |
| Phone #: |  | Fax # (*if applicable*): |  |
| **Date (*dd/mm/yyyy*):** |  | **Signature:** |  |

**Please fax the completed form to 705-494-3097. We will contact you if we require further information or if unable to register the patient with our services.**