HÔTEL-DIEU
ESTD GRACE 1888
HEALTHCARE

GERIATRIC OUTPATIENT SERVICES REFERRAL – GAP OR GMHOT

Tayfour Campus, 1453 Prince Road, Windsor, ON N9C 3Z4
Telephone: 519-257-5111 ext. 76955 Fax: 519-257-5197

PLEASE ENSURE REFERRAL FORM IS COMPLETELY FILLED OUT PRIOR TO SENDING OR IT WILL BE RETURNED

NOTE: Minimum Age Requirement for Referral is 65 and older

PATIENT INFORMATION

Last Name:	First Name:	Date of Birth:(MM/DD/YYYY)	Gender:

Street Address:	Unit #	City, Town:	Postal Code:	Health Card:	Version:

Is the patient capable of consent and making their own decisions? ☐ **Yes** ☐ **No**
If no, Please include the alternate contact information in full below

Primary Phone Number	Phone Number #2

Who will be contacted to schedule an assessment? ☐ **Patient** ☐ **Alternate Contact - Substitute Decision Maker (SDM) or Other**

ALTERNATE CONTACT INFORMATION

Full Name:	Relationship with patient:	Is this person the ☐ **SDM or** ☐ **Other**	Primary Phone Number	Phone Number #2

Street Address:	Unit #	City, Town:	Postal Code:	*****Required for Long Term Care Homes: Attach Power of Attorney Document*****

PRIMARY REASON(S) FOR REFERRAL

☐ Cognitive Assessment/Dementia	☐ Depression	☐ Responsive Behaviours	☐ Delusions
☐ Functional Decline	☐ Anxiety	☐ Hallucinations	☐ Paranoia/Suspicion
☐ Mobility and Falls	☐ Unstable Bipolar Disorder		
	☐ Unstable Schizophrenia		

Comments and other concerns:

Please list all of the patient's Medical Diagnoses:

Please provide details regarding the **GOALS** for this referral. What is the expectation of our involvement?

Are there any other doctors/specialists currently involved in the care of this patient? ☐ **Yes** ☐ **No** ***If Yes, please list below:***

Doctor:	Specialty:	Doctor:	Specialty:

REQUIRED:	Attach a List of **ALL** medications used/taken by the patient including vitamins and OTC meds with dosages and frequency.
REQUIRED:	Attach a copy of recent lab work that has been completed **within the past 6 months** of the date this referral is received. It must include: CBC & DIFF. lytes, TSH, glucose, Vit B12, ionized, calcium, creatinine, urea
OPTIONAL:	Any other relevant consult notes, CT, X-rays, MRI, ECG reports. Copies of memory and mood screenings within past year.

REFERRING PRACTITIONER INFORMATION - Note: The client must be under the care of a PCP in order to be eligible for services

Are you the patient's Primary Care Provider? ☐ **Yes** ☐ **No**
If No, Please list the PCP in the space provided below

****Note to PCP: Signing below confirms that you consent to our involvement & recommendations and will resume care upon discharge****

PRINT Physician/Nurse Practitioner Name:	Office Address:	
Signature AND Billing# (Required):	Phone Number:	Fax Number:

Name of Primary Care Practitioner if other than referring practitioner:

Signature AND Billing# (Required):

Your Office will receive a Fax confirmation that the referral was received or to request missing information.