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|---|--|---|---|--|
| <input type="checkbox"/> Lakeridge Health Oshawa
Ph: 905-576-8711x 4832
Fax: 905-743-5311 | <input type="checkbox"/> The Scarborough Hosp.
Ph: 416-431-8111
Fax: 416-289-2961 | <input type="checkbox"/> Peterborough Regional Health Ctr.
Ph: 705-743-2121 x 5021
Fax: 705-876-5058 | <input type="checkbox"/> Rouge Valley Health System
Ph: 416-281-7446
Fax: 416-281-7082 | <input type="checkbox"/> St. Paul's L'Amoreaux Ctr.
Ph: 416-493-3333
Fax: 416-352-5086 |
| <input type="checkbox"/> Carefirst Seniors & Community Services Assn.
Ph: 416-847-8941
Fax: 416-847-8942 | <input type="checkbox"/> Port Hope Community Health Ctr.
Ph: 905-885-2626x254
Fax: 905-885-6063 | <input type="checkbox"/> Community Care City of Kawartha Lakes
Ph: 705-879-4112
Fax: 705-880-1516 | <input type="checkbox"/> Oshawa Community Health Ctr.
Ph: 905-723-0036
Fax: 905-665-7178 | <input type="checkbox"/> Trent Hills Community Team
Ph: 705-653-1140x2139
Fax: 705-632-2023 |
| | | | | <input type="checkbox"/> Haliburton Highlands Health Services
Ph: 705-286-2140x3400
Fax: 705-286-0720 |

REFERRAL SOURCE: ED Referral Community Post Hospitalization Geriatric Emergency Management Nurse

TRIAGE: Urgent Non urgent

PATIENT NAME: _____ Date of Birth (D/M/Y): _____

Address: _____ City: _____

Postal Code: _____ Health Card Number: _____

Phone: (Res.): _____ (Alternate): _____ Can attend a clinic visit? Yes No

CONTACT PERSON INFORMATION:

Contact Person/SDM/Other: _____ Relationship to patient: _____

Phone: (Res.) _____ (Other): _____

Is interpreter required? Yes Language: _____ Call and speak with patient directly? Yes No

Alert - Do not call: _____ (name)

PHARMACY: _____

Phone #: _____ Fax #: _____

PRIMARY HEALTHCARE PROVIDER (MD/NP) NAME: _____

Address: _____ City: _____

Postal Code: _____ Phone: _____ Fax: _____

HEALTH INFORMATION: (please fill out as completely as possible)

REASON FOR REFERRAL TO GAIN: _____

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Multiple complex health problems | <input type="checkbox"/> Psychosocial problems | <input type="checkbox"/> Functional Decline | <input type="checkbox"/> Cognitive Decline |
| <input type="checkbox"/> At risk/have experienced falls | <input type="checkbox"/> Difficulty coping/isolation | <input type="checkbox"/> Safety concerns | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Medication assessment | <input type="checkbox"/> Mental Health/Addictions | <input type="checkbox"/> Other : | |

COMMUNITY SERVICES:

1. The applicant is currently linked/referred to these services in the community (please specify):

1. _____
2. _____

2. Is the applicant referred to or receiving any other geriatric services? (please specify):

1. _____
2. _____

3. Please attach all supporting documents including patient profile, medication list, consultations, recent lab/diagnostic reports, blood work.

Referring Healthcare Provider Name: (please print) _____

Signature _____

Billing # _____

Date _____