GAIN Geriatric Clinic REFERRAL form

□ Lakeridge Health Oshawa
1 Hospital Court
Oshawa, ON L1G 2B9
Phone: 905-576-8711 x 4832
Toll Free: 1-866-338-1778
Fax: 905-743-5311

□ The Scarborough Hospital
General Campus
3050 Lawrence Ave. E.
Scarborough, ON M1P 2V5
Phone: 416-431-8200 x 6355
Fax: 416-289-2961

□ Rouge Valley Health Centre
2867 Ellesmere Road
Toronto, ON M1E 4B9
Phone: 416-284-3118
Fax: 416-281-7384

□ Peterborough Regional Health Centre
Medical Outpatient, 1 Hospital Drive
Peterborough, ON K9J 7C6
Phone: 705-876-5021
Fax: 705-876-5058

Referral Source:	☐ ED Referral	☐ Community referral	☐ Post Hospitalization
Triage:	☐ Emergent 24-48 hours	☐ Urgent < 72 hours	☐ Non urgent < 1 – 2 weeks

Applicant Information:

Patient Name: _____ Address: _____

_____ City: _____ Postal Code: _____

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

Date of Birth: _____ Health Card Number: _____

Day Month Year

Whom does patient live with?_____

Pharmacy: _____

Phone #: _____ Fax #: _____

Contact Person Information:

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

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

Is contact person also Power of Attorney? ☐Yes ☐No Call and speak with patient directly? ☐Yes ☐No

Alert - Do not call: _____(name)

Primary Healthcare Provider (MD/NP) Name: _____

Address: _____ City: _____

Postal Code: _____ Phone: _____ Fax: _____

Health Information: (To enable us to assess urgency with which patients need to be seen, please fill out as completely as possible)

Reason for referral: _____

☐ Multiple complex health problems ☐ Psychosocial problems ☐ Functional Decline ☐ Cognitive Decline

☐ At risk for falls ☐ Difficulty coping ☐ Safety Concerns ☐ Other

☐ Have experienced falls ☐ Medication assessment

*Attach Supporting Documents:

- Patient Profile
- Medication List
- Consultations
- Recent/Relevant Lab/Diagnostic Reports (critical to assessment)

Currently linked/referred to these services in the Community:

1. _____
2. _____
3. _____

_____ _____

Primary Healthcare Provider Name: (please print) *Signature*

_____ _____

Date *Billing #*