GAIN
Geriatric Assessment & Intervention Network

Referral Form

*Note: Please refer only to one Team.
The referral will be triaged to the most appropriate GAIN team

SCARBOROUGH		DURHAM	NORTH EAST		
☐ **Scarborough Health Network:** ***General Site*** T: 416-431-8111 Fax: 416-289-2961	☐ **Carefirst Seniors & Community Services Association** T: 416-847-8941 Fax: 416-646-5111	☐ **Lakeridge Health Oshawa Hospital** T: 905-576-8711 x 34832 Fax: 905-743-5311	☐ **Port Hope Community Health Centre** T: 905-885-2626 x 254 Fax: 905-885-6063	☐ **Trent Hills Community Team (Campbellford)** T: 705-653-1140 x 2139 Fax: 705-632-2023	☐ **Peterborough Regional Health Centre** T: 705-743-2121 x 5021 Fax: 705-876-5058
☐ **Scarborough Health Network:** ***Centenary Site*** T: 416-281-7446 Fax: 416-281-7082	☐ **Senior Persons Living Connected** T: 416-493-3333 x 311 Fax: 416-352-5086	☐ **Carea Community Health Centre (Whitby)** T: 289-205-8642 x 1408 Fax: 905-665-7178	☐ **Community Care City of Kawartha Lakes (Lindsay)** T: 705-879-4112 Fax: 705-880-1516	☐ **Haliburton Highlands Health Services (Minden)** T: 705-286-2140 x 3400 Fax: 705-286-0720	

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

Address: _____ City: _____

Phone: _____ Other Phone #: _____ Sex: ☐ M ☐ F

Health Card Number: _____ Language: _____

Contact Person/SDM/POA: (REQUIRED)

Name: _____ Relationship: _____ Phone: _____

☐ **Patient has provided verbal consent for GAIN to contact Contact Person/SDM/POA**

Who should we contact to book appointment? ☐ **PATIENT** ☐ **CONTACT PERSON**

REASON FOR REFERRAL: (REQUIRED)

Please Circle all that apply

1. Cognitive decline affecting hygiene, managing medication, banking, driving and/or meal preparation
2. Complex medication regimen/polypharmacy
3. Recent falls or mobility changes
4. Recent physical or functional decline
5. Responsive behaviours (agitation, wandering, paranoia, hallucinations, inappropriate behaviours)
6. Caregiver(s) having difficulty coping

Patient can attend a clinic visit ☐ Yes ☐ No Reason:

***Attach supporting documents (within last year): patient profile, med list, consults, recent labs/diagnostics**

Failure to provide required documentation will delay appointment booking

Pharmacy: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Referred By: ☐ Primary Care ☐ GEM/ED ☐ Inpatient ☐ Specialist ☐ Family/Self ☐ Community Agency ☐ LHIN ☐ Other

Referral Source Contact information: _____ Date: _____

Billing#: _____ Signature: _____