

## Referral Form

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

SCARBOROUGH		DURHAM	NORTH EAST		
<input type="checkbox"/> Scarborough Health Network: <i>General Site</i> T: 416-431-8111 Fax: 416-289-2961	<input type="checkbox"/> Carefirst Seniors & Community Services Association T: 416-847-8941 Fax: 416-646-5111	<input type="checkbox"/> Lakeridge Health Oshawa Hospital T: 905-576-8711 x 34832 Fax: 905-743-5311	<input type="checkbox"/> Community Health Centres of Northumberland T: 905-885-2626 x 254 Fax: 905-885-6063	<input type="checkbox"/> Trent Hills Community Team (Campbellford) T: 705-653-1140 x 2139 Fax: 705-632-2023	<input type="checkbox"/> Peterborough Regional Health Centre T: 705-743-2121 x 5021 Fax: 705-876-5058
<input type="checkbox"/> Scarborough Health Network: <i>Centenary Site</i> T: 416-281-7446 Fax: 416-281-7082	<input type="checkbox"/> Senior Persons Living Connected T: 416-493-3333 x 311 Fax: 416-352-5086	<input type="checkbox"/> Carea Community Health Centre (Whitby) T: 289-205-8642 x 1408 Fax: 905-665-7178	<input type="checkbox"/> Community Care City of Kawartha Lakes (Lindsay) T: 705-879-4112 Fax: 705-880-1516	<input type="checkbox"/> 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 Check all that apply**

- Cognitive decline affecting hygiene, managing medication, banking, driving and/or meal preparation
- Complex medication regimen/polypharmacy
- Recent falls or mobility changes
- Recent physical or functional decline
- Responsive behaviours (agitation, wandering, paranoia, hallucinations, inappropriate behaviours)
- 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: \_\_\_\_\_