Alberta Health Services

Affix patient label within this box

Seniors Health & Geriatric Medicine Referral (Calgary Zone)

- Missing or incomplete information will delay processing.
- Please refer to Alberta Referral Directory for clarification of referral guidelines if required.
- Please Fax completed form to **Seniors Health & Geriatric Medicine**
  Fax 403-955-1514 Phone 403-955 -1525

Client Demographics

Date *(yyyy-Mon-dd)*	☐ Current Continuing Care Resident		
Last Name	First Name		Gender ☐ Male ☐ Female
Date of Birth *(yyyy-Mon-dd)*	Personal Health Care Number	Home Phone	Alternate Phone
Address		City	Postal Code

If Patient is unable to book his/her own appointment ***(Complete the information below)***

Contact Person Name	Relationship	Phone

☐ Patient Unable to speak/read/comprehend English *(Specify language spoken)* _____

Referring Source

Referring Source Name	Signature	Designation	Phone	Fax
☐ Family Physician aware of this referral *(if different from Referring Source)* Name of Family Physician _____			Phone	Fax

Service Requested *(check all that apply)*

Attach relevant past medical history, consults, medication, cognitive screening test, labs, if unavailable on NetCare

☐ **Seniors Health Clinic**
- ☐ Complex Medical Assessment
- ☐ Cognitive Assessment
- ☐ Medication Review

☐ **Calgary Fall Prevention Clinic**
- ☐ Falls *Number of falls in the past 12 months* _____

Urgent Request? ☐ No ☐ Yes, reason _____

For the service requested, what are the specific questions you would like answered?

_____

_____

If referred to other services for the same issue, please explain clear goals for Geriatric consultation:

_____

_____

Clinical Information *(check all that apply)*

Is patient currently medically stable? ☐ Yes ☐ No
Is patient at risk for hospitalization? ☐ Yes ☐ No

☐ Behaviour changes
☐ Depression/anxiety
☐ Mobility problems / Gait / Balance
☐ Severe persistent cognitive impairment
☐ Caregiver Stress
☐ Unintentional Weight Loss *(Amount Lost in past 6 months _____ kg).*
☐ Incontinence / Urine / Stool
☐ Active substance abuse

Safety Concerns _____

Provider/Services involved with Care/Consults

☐ Home Care ☐ Mental Health ☐ Others _____
☐ Pending Medical Consults *(list and specify times)* _____
☐ Previous Psychiatric Assessment Date *(yyyy-Mon-dd)* _____ MD/Location _____
☐ Previous Geriatric Assessment Date *(yyyy-Mon-dd)* _____ MD/Location _____
☐ Previous Neurocognitive Assessment Date *(yyyy-Mon-dd)* _____ MD/Location _____