Alberta Health Services

Affix patient label within this box

Geriatric Services Referral

Medicine Hat and Area

- Fax completed referral to **403.528.5647**
- Missing or incomplete information will delay processing
- Please ensure client is aware of this referral and that a reliable historian will accompany them to the appointment

All referrals require the following:

- ☐ List of Allergies
- ☐ Past Medical History
- ☐ List of Current Medications (include over the counter medications)
- ☐ Copies of Cognitive testing (MoCA, or any other), if applicable
- ☐ Laboratory investigations completed in last 6 months *(CBC, Creatine, Na, K, Cl, CO2, Albumin, Vitamin B12, TSH)*

Client Demographics

Date *(dd-Mon-yyyy)*		☐ Current Continuing Care Resident	
Last Name	First name		Gender
Date of Birth *(dd-Mon-yyyy)*	PHN/ULI	Home Phone	Alternate Phone
Address		City/Town	Postal Code
Contact Person *(Last Name, First Name)*		Relationship	Contact Phone

Referral Information

Reason for Referral

Service(s) Requested ***(check all that apply)***

- ☐ Cognitive Assessment
- ☐ Medication Review
- ☐ Complex Comorbidities
- ☐ Phone Consultation with Triage (GAT) Nurse

Clinical Concerns ***(check all that apply)***

- ☐ Functional Decline *(frailty, falls)*
- ☐ Urinary/Bowel incontinence
- ☐ Depression/Anxiety
- ☐ Caregiver Stress
- ☐ Weight Loss
- ☐ Behaviour Changes

Has client had CT-Head or MRI Brain done?

☐ No ☐ Yes ► Date *(dd-Mon-yyyy)* _____ Facility _____

Referral Source

Referring Provider	Designation/Prac ID	Phone	Fax
Family Physician *(if different from referring source)*		Phone	Fax

Office Use Only

Referral to

- ☐ Geriatrician
- ☐ Geriatric Assessment Team