



Last Name	
First Name	
PHN#	MRN#
Birthdate (dd-Mon-yyyy)	Physician

## Specialized Geriatrics Outpatient Referral

**Missing or incomplete information will delay processing.** Ensure a referral letter is attached and contact name of a person who will assist the client to the appointment.

<b>Client Demographics</b>	Last Name		First Name	
	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (yyyy-Mon-dd)	
	Address		City	
	Home Phone		Postal Code	
	Alternate Phone		Is this patient able to book his/her own appointment? <input type="checkbox"/> Yes <input type="checkbox"/> No, complete information below ▼	
<b>Referring Source</b>	Contact Person		Relationship	
	Referring Source		Phone	
	Name of Family Physician (if different from referring source)		Fax	
	Referring Program Area		PRACID Number	
	<input type="checkbox"/> Community Care Services (e.g. Home care)		<input type="checkbox"/> Emergency Department	
Reason for Referral (main concern)		<input type="checkbox"/> Other (specify) _____		
<b>Service Requested</b> (check all that apply) <input type="checkbox"/> Urgent appointment requested <input type="checkbox"/> Complex co-morbidities <input type="checkbox"/> Cognitive Assessment <input type="checkbox"/> Medication Review <input type="checkbox"/> Phone Consultation with Triage Nurse <input type="checkbox"/> Other (specify) _____		<b>Clinical Information</b> (check all that apply) <input type="checkbox"/> Behaviour Changes <input type="checkbox"/> Depression/Anxiety <input type="checkbox"/> Caregiver Stress <input type="checkbox"/> Mobility Problems/Gait/Balance <input type="checkbox"/> Incontinence/Urine/Stool <input type="checkbox"/> Weight Loss		
Is this patient currently medically stable? <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Consultation Required</b> <input type="checkbox"/> Consult only <input type="checkbox"/> Consult and Follow Up <input type="checkbox"/> Consult and Arrange Community Management		
<b>Providers/Services Involved with Care/Consults</b> (attach relevant past medical history, consults, medications, lab work, etc. if unavailable on netCARE)		Is the patient at risk for hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Community Care Services (e.g. Home Care) <input type="checkbox"/> Community Health Services (e.g. Public Health) <input type="checkbox"/> Previous Geriatrics Assessment Date (yyyy-Mon-dd) _____ Location _____ <input type="checkbox"/> Previous Neurocognitive Assessment Date (yyyy-Mon-dd) _____ Location _____ <input type="checkbox"/> Pending Medical Consults (please list and specify times) _____		<input type="checkbox"/> Mental Health <input type="checkbox"/> Day Program <input type="checkbox"/> Supportive Living		
<b>Special Requirements</b> <input type="checkbox"/> Requires oxygen <input type="checkbox"/> Hearing, visual impairment, homebound, etc. (specify) _____ <input type="checkbox"/> Activity limitations (e.g. walker, cane, etc.) _____ <input type="checkbox"/> Unable to speak/read/comprehend English (specify language spoken) _____ Name of translator _____ Phone _____				

Please fax completed form to Alberta Health Services Central Access - Edmonton Zone

Fax - 780.735.3553

Toll free fax - 1.866.979.3553

Phone - 780.401.2665