Alberta Health Services

Affix patient label within this box

Seniors Health & Geriatric Medicine Referral

- Incomplete referrals will be sent back to the referral source.
- **Ensure** a referral letter is attached and contact name of a person who will assist the client to the appointment.
- Please refer to **Alberta Referral Directory** for clarification of referral guidelines.
- Please **Fax** completed form to **Seniors Health & Geriatric Medicine (Calgary Zone)**
  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) (Required)***

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.

☐ Functional decline
☐ Complex Medical Assessment *(greater than 3 medical problems)*
☐ Dementia Management Challenges
☐ Complex Medication Issues
☐ Frailty *(Clinical Frailty Scale greater than 4, see ARD for guildelines)*
☐ **Calgary Fall Prevention Clinic**
☐ Falls *Number of falls in the past 12 months* _____
☐ Rural Clinic Referral
☐ SHOP Referral

Urgent Request? ☐ No ☐ Yes, reason _____

For the service requested, what are the specific questions you would like answered? *(Required)*

_____

_____

Clinical Information *(check all that apply)*

Is patient currently medically stable? ☐ Yes ☐ No
Is patient at risk for hospitalization? ☐ Yes ☐ No
☐ Homebound? ☐ Yes ☐ No
☐ Behaviour changes
☐ Depression/Anxiety
☐ Active substance abuse
☐ Unintentional Weight Loss *(Amount Lost in past 6 months _____ kg).*
☐ Incontinence (Urine and/or Stool)
☐ Mobility problems: Gait and Balance Impairment

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 _____