

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) _____		<input type="checkbox"/> Current Continuing Care Resident	
	Last Name _____		First Name _____	
	Date of Birth (yyyy-Mon-dd) _____		Personal Health Care Number _____	
	Address _____		Home Phone _____	
	City _____		Postal Code _____	
If Patient is unable to book his/her own appointment (Complete the information below) (Required)				
Contact Person Name _____		Relationship _____		Phone _____
<input type="checkbox"/> Patient Unable to speak/read/comprehend English (Specify language spoken) _____				
Referring Source	Referring Source Name _____		Signature _____	
	Designation _____		Phone _____	
<input type="checkbox"/> Family Physician aware of this referral (if different from Referring Source) _____		Phone _____		Fax _____
Service Requested (check all that apply)				
Attach relevant past medical history, consults, medication, cognitive screening test, labs.				
<input type="checkbox"/> Functional decline		<input type="checkbox"/> Frailty (Clinical Frailty Scale greater than 4, see ARD for guidelines)		
<input type="checkbox"/> Complex Medical Assessment (greater than 3 medical problems)		<input type="checkbox"/> Calgary Fall Prevention Clinic		
<input type="checkbox"/> Dementia Management Challenges		<input type="checkbox"/> Falls Number of falls in the past 12 months _____		
<input type="checkbox"/> Complex Medication Issues		<input type="checkbox"/> Rural Clinic Referral		
<input type="checkbox"/> SHOP Referral		Urgent Request? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is patient at risk for hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Homebound? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Behaviour changes		<input type="checkbox"/> Unintentional Weight Loss (Amount Lost in past 6 months _____ kg).		
<input type="checkbox"/> Depression/Anxiety		<input type="checkbox"/> Incontinence (Urine and/or Stool)		
<input type="checkbox"/> Active substance abuse		<input type="checkbox"/> Mobility problems: Gait and Balance Impairment		
Provider/Services involved with Care/Consults				
<input type="checkbox"/> Home Care <input type="checkbox"/> Mental Health <input type="checkbox"/> Others _____				
<input type="checkbox"/> Pending Medical Consults (list and specify times) _____				
<input type="checkbox"/> Previous Psychiatric Assessment		Date (yyyy-Mon-dd) _____		MD/Location _____
<input type="checkbox"/> Previous Geriatric Assessment		Date (yyyy-Mon-dd) _____		MD/Location _____
<input type="checkbox"/> Previous Neurocognitive Assessment		Date (yyyy-Mon-dd) _____		MD/Location _____