Capital Health

Geriatric Medicine Ambulatory Care

Referral Form

Phone: (902) 473-4822 Fax: (902) 473-7133 Centre for Health Care of the Elderly

1. Name ______________________ Mr ☐ Mrs ☐ Ms ☐ Miss ☐
   Address ______________________
   Town/City ______________________
   Phone # ______________________ Is patient aware of referral? YES ☐ NO ☐
   DOB ______________________ HCN ______________________
2. Contact person(s) ______________________ Phone # ______________________
3. Referring physician ______________________ Phone # ____________ Fax# ____________
4. Reason for Referral ______________________
   ____
5. **FOR MEMORY ASSESSMENTS**: Attach MMSE and lab results (CBC, electrolytes, glucose, urea, creatinine, calcium, TSH, vitamin B12) within the past 3 months.
6. Past Medical History ______________________
   ____
   ____
   ____
   ____
7. Medications ______________________
   ____
   ____
   ____
   ____
8. Living Arrangements
   ☐ Lives Alone ☐ Lives with Spouse
   ☐ Lives with Family Members ☐ Lives Alone with Supports (i.e. Home care)
   ☐ Other Living Arrangements (describe) ______________________
9. Other Consultants presently seeing patient ☐ Neurology ☐ Psychiatry ☐ Psychology
   ☐ Other ______________________
10. Referral request ☐ Routine (more than two weeks) ______________________
    ☐ Urgent (less than two weeks) ______________________
11. Please enclose any additional information which may be pertinent to the assessment of your patient.
12. Has the patient been assessed by a geriatrician previously? If so, please indicate which physician.

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