Regional Geriatric Program of Toronto
Affiliated with the University of Toronto

Sunnybrook
HEALTH SCIENCES CENTRE
when it matters MOST

Geriatric Services Referral

Tel: 416-480-6888 Fax: 416-480-4778

- Out-Patient Clinic
- Day Hospital
- Outreach Home Visits
- Falls Program

Reason(s) for referral:

☐ Geriatric Medicine Consultation ☐ Medication ☐ Wandering
☐ Cognitive Impairment ☐ Depression ☐ Caregiver Stress
☐ Behavioural Difficulties ☐ Functional Decline ☐ Speech/Communication
☐ Falls/Mobility ☐ Weight loss/nutrition ☐ Swallowing
☐ Incontinence ☐ Home Safety ☐ Other ______________________

Patient Information:

Surname: ______________________ First Name: ______________ ☐ M ☐ F Marital Status: ______

Address: ____
Postal Code

Phone: (____) ______________ Health Card #: _________________________________
Version Code

DOB: ________________________

Does the patient require a home visit (**i.e. is housebound**)? ☐ Yes ☐ No
Has patient/family been informed of referral? ☐ Yes ☐ No Does the patient live alone? ☐ Yes ☐ No
Does the patient speak English? ☐ Yes ☐ No If no, specify language spoken ________________

Contact Person for patient:

Name: ______________________ Relationship: ________________ Tel: (___) __________

Referring Physician:

Name: ________________________________ Tel: ______________ Billing #: __________

Address: ____ Signature: ______________

Family Physician (if different from Referring Physician):

Name: ________________________________ Tel: ______________ Billing #: __________

Address: ____ Signature: ______________

Past Medical History:

Medications:

Please fax to (416) 480-4778 along with any pertinent documentation, recent lab results, and consultations.

Clinic/Home visit Appointment booked: ______________@ __________ with ______________
2075 Bayview Avenue, Toronto, Ontario, M4N 3M5 Room HG-69

Revised Feb. 3, 2005