Sunnybrook HEALTH SCIENCES CENTRE

RGP REGIONAL GERIATRIC PROGRAM OF TORONTO

SPECIALIZED GERIATRIC SERVICES

2075 Bayview Ave, Toronto, ON, M4N 3M5, Tel: 416-480-6888, Fax: 416-480-4778

Client Information:

Surname:____________________First Name:______________________ Sex: ☐M ☐F Other: _________

Address:____Tel:_______________

Email:_______________________Health Card:_________________________MRN:______________

Date of Birth (YYYY/MM/DD):______________Who does the client live with? ________________________

Contact Person (re: booking appointment):

Name:________________Relationship:___________Tel:______________ Email:_________________

Has the family been informed of the referral? ☐ Yes ☐ No Is the client homebound? ☐Yes ☐No

Does the client speak English? ☐ Yes ☐ No Translator required? ☐Yes ☐No Language: ______________

Reason(s) for Referral

- ☐ Cognitive Impairment
- ☐ Behavioural difficulties
- ☐ Medication Review
- ☐ Weight loss/nutrition
- ☐ Speech/communication
- ☐ Sensory Impairment
- ☐ Caregiver Stress
- ☐ Depression
- ☐ Home Safety
- ☐ Falls/Mobility
- ☐ Pain
- ☐ Swallowing
- ☐ Incontinence

Main Concern(s):

Please attach:

- ☐ List of Medications
- ☐ Medical History
- ☐ Recent Consult Note(s)

Please Indicate Service:

☐ **Geriatric Medicine Clinic Consultation**
Comprehensive geriatric consultation

☐ **Geriatric Psychiatry Consultation – please send referral to:**
- Fax: 416-480-7842. Tel: 416-480-6833.
- If homebound - Fax: 416-480-5889. Tel: 416-480-4663.

☐ **Geriatric Outreach Team (GORT)**
In-home comprehensive geriatric consultation
Safety concerns for clinician ☐No ☐Yes ___________________

☐ **Falls Prevention Program (FPP)**
Comprehensive falls assessment and outpatient therapy. Client must be cognitively intact.

☐ **Geriatric Day Hospital (GDH)**
Interdisciplinary assessment and outpatient therapy. Client must require at least two of the disciplines: PT, OT, RN, SLP, RT, SW. Exclusion criteria: client requiring two person assist and/or cognitive impairment or behaviour that would prevent participation.

☐ **Learning the ROPES (LTR) for Mild Cognitive Impairment**
Program focused on optimizing cognitive health through lifestyle choices, memory training, and psychosocial support. Exclusion criteria: clients with markedly compromised independence in caring out daily responsibilities.

Referring Physician / NP

Name:_______________________Address:____________________________Tel:______________

Signature:______________Billing #__________Referral Date:________________Fax:______________

Current Family Physician / NP (if different from the referring physician / NP)

Tel:_______________

Name:_______________________Address:____________________________Fax:______________

We will contact your client / designate directly.