

2075 Bayview Ave, Toronto, Ontario, M4N 3M5

Tel: 416 480 6888 Fax: 416 480 4778

Client Information:

Surname: _____ First Name: _____ M F Marital Status: _____
 Address: _____
 Phone: (____) _____ Health Card # _____ VC: ____ MRN: _____
 Date of Birth (YYYY/MM/DD): _____ Who does the client live with? _____

Contact Person (re: booking appt):

Name: _____ Relationship: _____ Tel: _____
 Has family been informed of referral? Yes No Is the client homebound? Yes No
 Does the client speak English? Yes No Translator required? Yes No
 If No, specify language spoken: _____

Reason(s) for Referral (check all that apply)

- Cognitive Impairment
- Behavioural difficulties Depression
- Falls/Mobility Home Safety
- Medication Review Pain
- Weight loss/nutrition Swallowing
- Speech/communication Caregiver Stress
- Incontinence/constipation bowel/bladder
- Other _____

Main Concern (s) to be Addressed:

Please attach:

- List of Medications
- Medical History
- Recent Consult Note

Indicate Service:

- Geriatric Medicine Clinic Consultation**
Comprehensive geriatric consultation with medical resident and geriatrician.
- Geriatric Outreach Team**
In-home comprehensive geriatric consultation with PT or RN with possible linking to other specialized geriatric or community resources.
- Falls Prevention Program**
Comprehensive Falls Assessment, and outpatient therapy. Must be cognitively intact.
- Geriatric Day Hospital**
Interdisciplinary assessment and outpatient therapy. Client must require two or more of the following services: physiotherapy, occupational therapy, speech-language therapy, recreation therapy. Exclusion criteria include client requiring more than one person's assistance for transfer/ambulation, and cognitive impairment or behaviour that would prevent participation.

Referring Physician

Name: _____ Address: _____ Tel: _____
 Signature: _____ Phys Ref # _____ Fax: _____

Current Family Physician (if different)

Tel: _____
 Name: _____ Address: _____ Fax: _____

We will contact your client/designate directly.