GAIN Geriatric Clinic REFERRAL form

☐ Lakeridge Health Oshawa
1 Hospital Court
Oshawa, ON L1G 2B9
Phone: 905-576-8711 x 4832
Toll Free: 1-866-338-1778
Fax: 905-743-5311

☐ The Scarborough Hospital
General Campus
3050 Lawrence Ave. E.
Scarborough, ON M1P 2V5
Phone: 416-431-8200 x 6355
Fax: 416-289-2961

☐ Rouge Valley Health Centre
2867 Ellesmere Road
Toronto, ON M1E 4B9
Phone: 416-284-3118
Fax: 416-281-7384

☐ Peterborough Reg'l Health Centre
Medical Outpatient, 1 Hospital Court
Peterborough, ON K9J 7C6
Phone: 705-876-5021
Fax: 705-876-5058

Referral Source: ☐ ED Referral ☐ Community referral ☐ Post Hospitalization
Triage: ☐ Emergent 24-48 hours ☐ Urgent < 72 hours ☐ Non urgent < 1 – 2 weeks

Applicant Information:

Patient Name: _____ Address: _____
_____ City: _____ Postal Code: _____
Phone: (Res.): _____ (Other): _____
Date of Birth: _____ Health Card Number: _____
Day Month Year
Whom does patient live with?_____

Pharmacy: _____
Phone #: _____ Fax #: _____

Contact Person Information:

Contact Person/SDM/Other: _____ Relationship to patient: _____
Phone: (Res.) _____ (Other): _____
Is contact person also Power of Attorney? ☐Yes ☐No Call and speak with patient directly? ☐ Yes ☐ No
Alert - Do not call: _____(name)

Primary Healthcare Provider (MD/NP) Name: _____
Address: _____ City: _____
Postal Code: _____ Phone: _____ Fax: _____

Health Information: (To enable us to assess urgency with which patients need to be seen, please fill out as completely as possible)

Reason for referral: _____

☐ Multiple complex health problems ☐ Psychosocial problems ☐ Functional Decline ☐ Cognitive Decline
☐ At risk for falls ☐ Difficulty coping ☐ Safety Concerns ☐ Other
☐ Have experienced falls ☐ Medication assessment

*Attach Supporting Documents:

- Patient Profile
- Medication List
- Consultations
- Recent/Relevant Lab/Diagnostic Reports (critical to assessment)

Currently linked/referred to these services in the Community:

1. _____
2. _____
3. _____

_____ _____
Primary Healthcare Provider Name: (please print) *Signature*

_____ _____
Date *Billing #*

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