Trillium Health Partners

SENIORS' SERVICES REFERRAL FORM

Central Intake
Seniors' Services – Trillium Health Partners
Tel: (416) 521-4090 • Fax: (416) 521-4116

OFFICE USE ONLY: Date Received (dd/mm/yy): _____
Date Reviewed (dd/mm/yy): _____ ID#: _____

PLEASE COMPLETE ALL FIELDS AND SIGN THE FORM.
MISSING OR INCOMPLETE INFORMATION
WILL DELAY PROCESSING OF REFERRAL.

Name of Client: _____ ☐ M ☐ F
Surname *First Name*

Address: _____
Street Number and Name *Apartment* *City* *Province* *Postal Code*

Phone: _____ Marital Status: _____

Health Card #: _____/_____/_____ _____ Date of Birth: _____
Version Code *DD / MM / YYYY*

Person to contact re booking appointment: _____ Phone *(daytime)*: _____

Relationship to client: _____ Phone *(evening)*: _____

Is CCAC involved? ☐ No ☐ Yes ☐ Unsure

Does the client have a Substitute Decision Maker or Power of Attorney? ☐ Unsure ☐ No ☐ Yes (complete information below if different from above)

Name: _____ Phone *(daytime)*: _____ Phone *(evening)*: _____

Reason for Referral (check all that apply):

☐ Functional Decline
☐ Cognitive Impairment
☐ Medication Management/ Polypharmacy
☐ Psychosocial
☐ Incontinence
☐ Constipation
☐ Weight Loss/Nutrition
☐ Falls
☐ Other (specify): _____

Main Concern(s) to be addressed: _____

_____

_____

_____

Indicate the service of preference (check all that apply):

☐ **Geriatric Assessment Clinic:**
Assessment with MD and/or Nurse Practitioner

☐ **Falls Prevention/Bone Health Program:** *Consultation with MD and/or NP and PT and 6 week exercise/education program; client must be able to walk 25 m and learn new information.*

☐ **Regional Continence Home Visits (Nurse led):** *assessment and education for moderately to severely housebound frail seniors*

☐ **Regional Geriatric Medical Outreach:** *In home medical/physical, cognitive, functional and psychosocial consultation by inter-professional team; If client is not housebound, specify why reason home visit required:*

_____

Medical History: ☐ See Attached

_____

_____

Medications: Please attach medication profile and recent lab results less than 3 months.

_____

Infection Control: Has the client ever had any of the following infections (check all that apply)?

☐ MRSA ☐ VRE ☐ c. Difficile ☐ TB ☐ ESBL

Referral from: ☐ Emergency Dept ☐ Acute Care ☐ Primary Healthcare ☐ Other _____

Name of Family MD / NP *(please print)*: _____ Phone: _____ Fax: _____

Name of Referring MD / NP *(please print)*: _____ Phone: _____ Fax: _____

Signature of Referring MD / NP: _____ OHIP Billing #: _____ Date *(dd/mm/yy)*: _____

OFFICE USE ONLY:

Please fax with relevant notes, recent lab results and/or ECG.

# of pages being faxed: _____

****We will contact your patient directly after receiving this consult request. Thank you.**

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