ST JOSEPH'S HEALTH CARE LONDON

Specialized Geriatric Services Intake/Referral Form

Tel: (519) 685-4046 Fax: (519) 685-4020

Mailing Address: 801 Commissioners Road East, London ON N6C 5J1

What service does this client require?

☐ Musculoskeletal Unit ☐ Regional Geriatric Program Outreach ☐ Ambulatory Care/Geriatrician Consult

☐ Geriatric Rehabilitation Unit ☐ Regional Psychogeriatric Program Outreach ☐ Geriatric Day Hospital

☐ Aging Brain & Memory Clinic ☐ GDH – Parkinson's Education Program

☐ Geriatric Mental Health (☐ Consult only ☐ Consult & Follow-up ☐ Consult/family/spousal assessment)
(☐ Home Visit ☐ Office Visit)

If patient is in hospital or LTC facility:
Facility: _____ Date of Admission: _____

Address/Unit: _____ Phone #: _____

Last Name:	First Name:	Sex: ☐ M ☐ F	Marital Status
Street Address:	City:		Postal Code:
Telephone #:	Date of Birth (yy-mm-dd):	OHC# (+ version code):	Language: ☐ English ☐ Other: _____

Contact Person:
Name: _____ Home #: _____ Work #: _____

Reasons for referral: (list & include recent changes)

_____

_____

_____

_____

_____

PLEASE ATTACH:
MEDICAL/PSYCHIATRIC HISTORY ♦ MEDICATION LIST ♦ LAB RESULTS ♦ RELEVANT CONSULTS ♦ ANY ALLERGIES
If Geriatric Mental Health referral please provide the following:
Type of Substance Abuse (if any) eg: ETHOL, prescription, OTC
Other Concerns eg. Paranoia, delusions, safety, dementia, finances, family dysfunction

Family Physician

Telephone: Fax:

Date of Referral:

Physician authorization of Referral

_____ _____

(Print Name) (Signature)

_____
(yy-mm-dd)