SPECIALIZED GERIATRIC SERVICES CENTRAL INTAKE Referral Form

Behavioural Supports Ontario (BSO)
Geriatric Medicine
Geriatric Mental Health

Fax: 1-855-406-2163
Phone: 1-905-521-2100 Ext.12221
www.rgpc.ca/centralintake

A - SERVICES REQUESTED

☐ **Geriatric Medicine**
Provides medically complex older adults with comprehensive geriatric assessment, diagnosis & treatment recommendations.
Typical concerns: frailty, balance/ falls, continence, cognitive decline, polypharmacy

☐ **Geriatric Psychiatry**
Provides persons with comprehensive geriatric psychiatry assessment.
Typical concerns: responsive behaviour, psychosis, mood disorder, cognitive decline, polypharmacy

☐ **Behavioural Supports Ontario**
Help understand the causes of responsive behaviours, and develop non-pharmacological strategies to manage behaviour. Works collaboratively with clients, caregivers & providers.

B - PATIENT DEMOGRAPHICS

First Name: _____ **Last Name:** _____ **Phone:** _____

Address: _____

DOB: ____/____/____ (dd mm yyyy) **Gender:** ○ male ○ female ○ other/undisclosed **HCN:** _____ - _____ (# # # # # # # # # # version code)

Primary Care Practitioner (PCP): _____ **PCP Phone:** _____

C - ALTERNATE CONTACT

Contact Person for Appointment ○ Patient ○ Alternate Contact ○ Referrer

First Name: _____ **Last Name:** _____ **Phone:** _____

Relationship to Patient: ○ Spouse ○ Child ○ Other: _____ **Alt Phone:** _____

D - HEALTH INFORMATION

Preferred Language: ○ En ○ Fr ○ Other (specify): _____ **Needs Interpreter:** ○ Yes ○ No

Living Situation: ○ Alone ○ with Spouse/Partner ○ with Family/Caregiver ○ Retirement Home ○ Other: _____

RELEVANT MEDICAL & PSYCHIATRIC HISTORY:

IMPORTANT!: Attach the Following Supporting Documentation *(Not required for BSO referrals. Check all attached)*

☐ 1. Cumulative Patient Profile (w/ meds list)
☐ 2. Relevant Consultation Reports
☐ 3. Lab: CBC, Lytes, BUN, Creatinine, FBS, TSH, Calcium, Albumin, B12
☐ 4. Recent Diagnostics: Head CT/MRI, ECG

E - REASON FOR REFERRAL

Why are you referring now? What has changed? Risk and safety issues? (e.g., behavioural changes, frailty, falls)

If there is a preferred physician or service then please specify below:

F - REFERRER INFORMATION

Referrer Role: ◉ Primary Care ○ Hospital Provider ○ Other (specify): _____

Name: _____ **Phone #:** _____

Organization: _____ **Fax #:** _____

CONSENT: Patient is aware of this referral and has consented to their health information being collected from various sources to make decisions regarding care. ○ Yes ○ No

Referrer Signature: _____ **Date** ____/____/____ (dd mm yyyy) **OHIP Billing #:** _____

Participating Providers: *Alzheimer Society of Brant, Haldimand Norfolk, Hamilton, Halton | Community Addictions and Mental Health Services Hamilton Health Sciences | Niagara Health | St. Joseph's Healthcare Hamilton | Hamilton Niagara Haldimand Brant Local Health Integration Network*

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