GERIATRIC DAY HOSPITAL REFERRAL FORM

Orillia Soldiers' Memorial Hospital
170 Colborne St. W., Orillia, ON L3V 2Z3
Telephone: 705-325-2201 Ext 3850 Fax: 705-330-3211

PATIENT DEMOGRAPHICS

Name: _____ Date of Birth (Y/M/D): _____
Address:_____ Telephone (H) : _____
_____ Postal Code: _____
Health Card Number: _____ Version Code: _____

Who should we contact to book/confirm appointments?
Client _____ or
Other _____ Relationship: Next of Kin/POA/Other _____
Telephone (H): _____ Telephone (W): _____

REFERRAL INFORMATION

Physician -please print	Telephone	Facsimile

DIAGNOSIS:

REASON FOR REFERRAL:
(i.e. What do you want us to help with?)

Specialist Consults by Physician referral only:
Please indicate:
- ☐ Geriatrician
- ☐ Geriatric Psychiatrist (telemedicine)

OTHER RELEVANT CONCERNS:
- ☐ Falls
- ☐ Mobility issues
- ☐ Multiple medical problems
- ☐ Medication review requirement
- ☐ Need for coping ability enhancement
- ☐ Health/ safety promotion/ prevention
- ☐ Cognitive changes
- ☐ Communication difficulties
- ☐ Swallowing issues
- ☐ Bowel/ bladder dysfunction
- ☐ Caregiver stress
- ☐ Difficulty navigating community support services

Please be aware that any discipline (Occupational Therapy, Nursing, Nutrition Physiotherapy, Social Work or Speech Language Pathology) may be involved in the client's care as part of the referral to the OSMH Geriatric Day Hospital.

Please include information on the following: ☐ see attached reports
Allergies: _____
Past Medical History: _____
Medications: _____

Attach *Relevant* DI / Lab: i.e. CBC, Lytes, BUN, Cr, LFTs, TSH, Folic Acid, B12, CT, X-rays, Bone scan/density

SUPPORT AGENCIES INVOLVED:

CCAC	Cancer Society	Veterans Affairs	Support Groups	Private pay Assistance
Alzheimer Society	Helping Hands	Hospice	Meals on wheels	Other (please specify) _____

Physician Signature: _____Billing Number:_____

Date: (Y/M/D): _____