

**Patient Demographic Label**

**GERIATRIC DAY HOSPITAL**

**Referral Form**

P) 613-721-3808 F) 613-721-4767

Internal QCH External

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| **Requirements for Processing of GDH Referral (must be attached to the referral):**  Completed blood work/Urinalysis results (if done within last 6 months)  CBC, Electrolytes, Creatinine, GFR, Glucose (Random), ALT, Calcium, BUN, CR and Vitamin B12, TSH, Ferritin, Mg+, AST Total billi, ALP, GGT, EKG  Head CT has been ordered in the last year due to Cognitive decline  Diagnostic Imaging  Past Medical History  Additional documentation attached (ex: Discharge Summary, Pertinent Specialist notes for the past 2 years)  Previous copies of MOCA/MMSE Testing/Trails:  Yes  No |
| **Reason for referral:**  Mobility  Functional Decline  Caregiver Stress  Cognition  Future Planning  Mental Health  Falls (in the last year)  Home Safety  Polypharmacy or medication  Other: management |
| Non-urgent  Urgent **Reason for Urgency:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How many known Emergency visits in the last year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Transportation to GDH:  Family/Friend  Volunteer  Self  Taxi  Para Transpo  Walk  OC Transpo (City Bus)  Current driver’s license:  Yes  No  Unknown  Is driving an issue that requires further testing:  Yes  No  Has driving been discussed with patient?  Yes  No  If the Ministry of Transportation has been notified, please indicate:  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (DD/MM/Year)  If coming by Para Transpo, has an application been initiated?  Yes  No  Is the Champlain (LHIN) Home and Community Care involved?  Yes  No  Name of Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Previous/Current referrals made and please forward notes:**  Health Links Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  GPCSO Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  PCO Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Falls prevention Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Mobility aids currently being used:**  Cane  Walker  Wheelchair  Other    **Any safety risks identified around attending program?**  Wandering  Aggressive Behavior  Does the patient have a Family Doctor?  Yes  No  When was the patient last appointment with the Family Doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Additional Pertinent Info:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Referral Source:**  Form completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Profession: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Printed name of Referring Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  OHIP billing #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **I have discussed with the patient and caregiver the commitment of attending an initial assessment and if accepted to the program will attend two half days a week for 4-6 weeks.**  **The patient is aware, agreeable and consents to referral and sharing of health information?  Yes  No If no, unable to proceed with the referral** |

**Referral Criteria for Geriatric Day Hospital Program**

* Over 65 years of age
* Require assessment and interventions from at least two disciplines: Physician, Nursing, Occupational Therapy, Physiotherapy, Social Work
* Independent with transfers or minimal assistance of one person
* Independent with mobility aid (i.e., cane, walker, wheelchair)
* Transportation options available
* Medically Stable

**Exclusion Criteria:**

* Advanced Dementia
* Wandering
* Inappropriate social behavior (e.g., verbal, or physical aggression)
* Requires assistance of 2 people for transfers
* Requiring pain management only
* Unmanaged Urine/Bowel incontinence
* Requiring Physiotherapy only – GDH is not Rehabilitation Clinic