

**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 [ ]  UnknownIs driving an issue that requires further testing: [ ]  Yes [ ]  NoHas driving been discussed with patient? [ ]  Yes [ ]  NoIf 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 [ ]  NoIs 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 [ ]  NoWhen 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