Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street, Richmond Hill ON L4C 4Z3
905-883-1212

Cortellucci Vaughan Hospital
3200 Major Mackenzie Drive West, Vaughan ON L6A 4Z3
905-417-2000

GERIATRIC OUTREACH SERVICES REFERRAL FORM

Telephone: 905-883-1212 Ext. 3895 **Fax: 905-883-2016**

Name of Client: _____
Surname First name

Address: _____
Street Name and Number Apartment City Province Postal Code

Phone No. _____ Marital Status _____ ☐ Male ☐ Female

Health Card No. _____ Version code _____ DOB _____
dd/mm/yyyy

Contact Person _____ Relationship _____ Phone No. _____

Does the client/substitute decision maker agree to referral and sharing of information within the circle of care? ☐ Yes ☐ No

INSTRUCTIONS: Please indicate request(s) for referral. Complete the medical information section below.

REASON FOR REFERRAL

- ☐ Functional Difficulties: ADL/IADL
- ☐ Behavioural Difficulties
- ☐ Verbal/Physical Aggression
- ☐ Cognition/Dementia
- ☐ Confusion
- ☐ Delusions/Hallucinations
- ☐ Wandering
- ☐ Home Safety
- ☐ Mobility/Falls
- ☐ Incontinence
- ☐ Poly pharmacy/Medications
- ☐ Caregiver Stress
- ☐ Depression/Anxiety
- ☐ Psychosocial
- ☐ Weight loss/Nutrition

MEDICAL INFORMATION

Main Concern(s):

Medical History – Medication:

BILLING # _____

Name of Referring MD (please print) _____ Phone No. _____

Signature of Referring MD/NP _____ Date: _____
dd/mm/yyyy

Name of Family MD (please print) _____ Phone No. _____

Signature of Family MD _____ Date: _____
dd/mm/yyyy

PLEASE FAX TO 905-883-2016 ALONG WITH RELATED CONSULTATION NOTES AND/OR RECENT LAB RESULTS

FOR HOSPITAL AND OFFICE USE ONLY

Requested Service: ☐ Clinical Nurse Specialist ☐ Geriatrician ☐ Occupational Therapist ☐ Social Worker

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(Sept 2009, Rev. Dec 2013)