Mackenzie Richmond Hill Hospital
10 Trench Street
Richmond Hill, Ontario
L4C 4Z3

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 ____________ yyyy/mm/dd

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 REFFERAL	MEDICAL INFORMATION
☐ Functional Difficulties: ADL/ IADL	Main Concern(s):
☐ Behavioural Difficulties	
☐ Verbal/ Physical Aggression	
☐ Cognition/Dementia	
☐ Confusion	
☐ Delusions/ Hallucinations	
☐ Wandering	
☐ Home Safety	
☐ Mobility/ Falls	Medical History - Medication:
☐ Incontinence	
☐ Poly pharmacy/ Medications	
☐ Caregiver Stress	
☐ Depression/ Anxiety	
☐ Psychosocial	
☐ Weight loss/ Nutrition	

BILLING # ____________

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

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

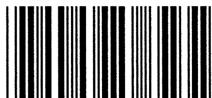
Name of Family MD (please print) ____________ Phone No. ____________

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

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)