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Geriatric Assessment Program Referral

Geriatric Assessment Program
Greater Niagara General Site
Allied Health Building
5672 North Street
Niagara Falls, ON L2G 1J4

Referral Date: ____________________ (dd/mm/yyyy)

Fax to: 905–358–4972
Telephone: 905–358–4944

Patient Information (*Affix Sticker if available*)

Last Name: ____________________ First name: ____________________

DOB: (dd/mm/yyyy) ____________________ Gender: ☐ M ☐ F ☐ Other

Address: ____________________

____

____

Health Card No/Version: ____________________ Phone: ____________________

Contact Person (NOK / SDM / POA)

☐ *Patient consents for geriatric assessment program to contact person named below*

Name (first and last) ____________________

Relationship to Patient ____________________

Phone Number ____________________

Reason for Referral (*Check all that apply*)

- ☐ Comprehensive geriatric assessment
- ☐ Cognition / memory assessment
- ☐ Behavioural and psychological symptoms of dementia
- ☐ Polypharmacy / medication review
- ☐ Other:
- ☐ Mobility and falls
- ☐ Osteoporosis
- ☐ Frailty
- ☐ Caregiver stress

Please attach relevant past medical and psychiatric history, medications, other specialist consultations, and discharge summaries within the past year.
The following investigations are required to expedite the referral: ***CBC, electrolytes, TSH, B12, calcium, ECG.***

Referrer Information

Primary Care Provider: ____________________ Billing #: ____________________

Address, Phone and Fax #: ____________________

Referring Practitioner: ____________________ Billing #: ____________________

Address, Phone and Fax #: ____________________

Referring Practitioner Signature: ____________________

We will contact patient/next of kin directly for an appointment date and location. Thank you.

Chart Copy – Do Not Destroy