

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

Name (first and last) _____

Relationship to Patient _____

Phone Number _____

Reason for Referral *(Check all that apply)*

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

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.



REF49

Chart Copy – Do Not Destroy