PATIENT LABEL

(MANDATORY: Referral will not be processed without a patient demographic label)

QUEENSWAY CARLETON GERIATRIC DAY HOSPITAL

REFERRAL FORM

(QCH Internal use only)

Phone: 613-721-3808 Fax: 613-721-4767

Consent

The patient is aware, agreeable and consents to referral and sharing of health information?
☐ Yes ☐ No If "No", we are unable to proceed with the referral.

Contact for Appointment: ☐ Patient ☐ Care Partner ☐ Both

Patient Information

Email:

Language: ☐ English ☐ Other: Translator required: ☐ Yes ☐ No

Living Arrangements: ☐ Alone ☐ Spouse/Partner ☐ Retirement Home ☐ Care Partner ☐ Family ☐ Other:

Care Partner (Primary) Contact Information

Name: Relationship to Patient:

Phone: Alternative Phone:

Address: Email:

Reasons for Referral (2 or more required)

☐ Cognition ☐ Function ☐ Falls ☐ Mobility
☐ Mood ☐ Care Partner Support ☐ Medication Review ☐ Driving
☐ Future Planning ☐ Risk/Safety Concerns ☐ Other: ____________

Pertinent Information

Has a report been submitted to the Ministry of Transportation during current admission?	☐ Yes ☐ No
Is the person currently receiving active chemo &/or radiation therapy?	☐ Yes ☐ No
Has the person had a recent delirium? If "Yes", when did it start (yyyy-mm-dd):	☐ Yes ☐ No
Has the person been previously assessed by a specialized geriatric service? If "Yes", by whom and when (yyyy-mm-dd):	☐ Yes ☐ No

Additional Information: ______________________________

____

____

____

____

Referral Source	
Name:	
Profession:	Phone:
Unit:	Date:

Referring Physician:	**Primary Care Provider (PCP):**
Name:	Name:
OHIP Billing #:	Phone:
Phone:	Fax:
Fax:	

Referral Criteria for Geriatric Day Hospital Program

- 65 years and over
- Medically stable
- Requires specialized geriatric assessment and intervention
- Has a valid Ontario Health Insurance Plan (OHIP) card

Exclusion Criteria:

- Advanced Dementia
- Wandering/Exit seeking
- Inappropriate social behaviour (e.g., verbal, or physical aggression)
- Requires assistance of 2 persons for transfers
- Unmanaged urine/bowel incontinence
- Pain management only
- Individuals who live in a long-term care facility