SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Geriatric Outreach Services
Tel. 905-895-4521, ext. 6317
Fax. 905-853-2222

Health Record #: _____ Complete or place barcoded patient label here
Patient Name: *(Print first, last)* _____
DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Account #: _____ Date of Admission: dd / mm / yy

Geriatric Outpatient Services Referral Form

❑ ***In-Home Assessment - Geriatric Outreach Service*** ❑ ***Long-Term Care - Nurse Led Outreach/Acute Mental Health OTN Service***
❑ ***Geriatric Assessment Clinic***

Patient Name: *(print first, last)*	**Sex:** ❑ Male ❑ Female
Address: Street Number and Name Apartment City Province Postal Code	
Phone Number Home:	**Marital Status:**
Health Card #:	**Version Code:** / **Date of Birth:** dd / mm / yy
Contact Person: *(print first, last)*	
Relationship to Patient:	**Phone Number:**

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

REASON FOR REFERRAL

- ❑ ADL/Instrumental ADL
- ❑ Caregiver stress
- ❑ Cognition/Dementia
- ❑ Delirium
- ❑ Delusions/Hallucinations
- ❑ Depression/Anxiety
- ❑ Home safety
- ❑ Incontinence
- ❑ Medication
- ❑ Mobility/falls
- ❑ Psychosocial
- ❑ Wandering
- ❑ Weight loss/Nutrition

MEDICAL INFORMATION

Main Concern(s):

Medical History:

Referral Source:	**Phone Number:** ( )
Name: *(print first, last)*	**Date:** dd / mm / yy
Name of Family MD: *(print first, last)*	**Phone Number:**
Signature of Referral Source:	**Date:** dd / mm / yy

PLEASE FAX TO 905-853-2222 WITH RELATED CONSULTATION NOTES, CURRENT MEDICATION LIST AND/OR RECENT LAB RESULTS