Appendix 2: Referral Form Geriatric Medicine Ambulatory Care

Capital Health

Geriatric Assessment _____

Memory Assessment _____

Phone (902) 473-7183 Fax (902) 473-7133 **Centre for Health Care of the Elderly**

1. Name: _____ Mr ☐ Mrs ☐ Ms ☐ Miss ☐

   Address: _____

   Town/City: _____

   Phone #: _____ DOB: _____

   Health card # _____

2. **Contact person:** _____ **Phone # :** _____

3. Referring doctor: _____ Phone #: _____

4. Reason for Referral: _____

5. Past Medical History: _____

   (Brief Description) _____

6. Medications: _____

7. Living Arrangements:
   - ☐ Lives Alone
   - ☐ Lives with Spouse
   - ☐ Lives with Family Members
   - ☐ Lives Alone with Supports (i.e. Home care)
   - ☐ Other Living Arrangements (describe) _____

8. Other consultants presently seeing patient:
   - ☐ Neurology
   - ☐ Psychiatry
   - ☐ Psychology
   - ☐ Cardiology
   - ☐ Other _____

9. Referral request:
   - ☐ Routine (more than two weeks) _____
   - ☐ Urgent (less than two weeks) _____

10. Please enclose any additional information which may be pertinent to the assessment of your patient (blood work, tests, etc…).

11. Has the patient been assessed by a geriatrician previously? If so, please indicate which physician.