St. Joseph's Healthcare Hamilton

REFERRAL FORM

Ph: 905-573-4818 Ext 34818
Fax: 905-573-4820

SJH Geriatric (HOAP) Clinic
2757 King St Hamilton
L8G 5E4

Patient Name: _____

Address: _____

City: _____ Postal Code: _____

Telephone: _____

Date of Birth: _____ (must be 65years old)

HIN: _____ Version: _____

Contact Person: _____ Relationship: _____

Telephone: _____ Bus./Cell: _____

Living Arrangement:

☐ Alone ☐ Family ☐ Home
☐ Apartment ☐ Supportive Hsg.
☐ LTC Facility ☐ Retirement Home

Facility Name: _____

Family Physician: _____

Ph: _____ Fax: _____

Language: _____

What Is the Reason for Referral? (*ELABORATE*)

☐ Falls ☐ Incontinence ☐ Parkinson's
☐ Medical review ☐ Physical Decline ☐ Heart Failure
☐ Acute Confusion ☐ Memory changes ☐ Weight loss
☐ Depression ☐ Hallucinations ☐ Delusions
☐ Dementia ☐ Behavior changes ☐ Elder Abuse
☐ Medication management ☐ Aggressive Behaviors
☐ Caregiver Burden/stress ☐ Substance Abuse/Misuse
☐ Wandering/Exit Seeking

THE PATIENT SHOULD BE ACCOMPAINED BY A CAREGIVER TO APPOINTMENT

Please state if previously seen by a geriatrician: `

Medications/Dosages ☐ list attached

Past Medical History :(Forward any consultations)

Psychiatric History:

Is Patient Known to Community Care Access Centre? ☐ Yes ☐ No ☐ Unknown

**Please forward most recent bloodwork and any investigations, (e.g. CT scan, EKG) which have been completed. IF BLOODWORK/URINALYSIS HAVE NOT BEEN COMPLETED WITHIN THE PAST MONTH, WE WOULD RECOMMEND THE FOLLOWING:

o CBC WITH DIFF (WBC)	o ELECTROLYTES (Bi Carbonate)	o CT SCAN BRAIN RESULTS (If done)	
o CREATININE/BUN	o TSH	o ALBUMIN	o URINE, R&M AND C&S
o CALCIUM	o B12/ RBC-FOLATE	o GLUCOSE	o ECG

Referral Source

Print Name _____ Discipline _____ Phone # _____ FAX # _____

MD Signature: _____ OHIP Billing #: _____ Date _____

Physician Consultation Letters/Patient Profiles Accepted in Lieu of Referral Form Providing Info on Referral Is Included

**** *Missing Information Does Delay The Referral Process* ****