THE NIAGARA HEALTH SYSTEM
GREATER NIAGARA GENERAL SITE

GERIATRIC ASSESSMENT PROGRAM

OUT-PATIENT REFERRAL
TELEPHONE # 905-358-4944
FAX # 905-358-4972

Date Referred: _____

Patient Name: _____ Sex: **M F**

Address: _____ P.C.: _____

_____

Phone #: _____ D.O.B.: _____

Health Card #: _____

Referring Dr: _____ Phone #: _____

Family Dr: _____ Phone #: _____

Next of Kin: _____ Phone #: _____

Relationship: _____

Contact Person: _____ Phone #: _____
(Other than the patient)

Relationship: _____

REASON FOR REFERRAL: _____

_____

_____

_____

REFERRING PHYSICIAN'S SIGNATURE: _____

RECENT BLOOD WORK (i.e. CBC, LYTES, B12, TSH), AND ECG RESULTS MUST ACCOMPANY ALL SIGNED REFERRALS. REFERRALS WILL NOT BE PROCESSED WITHOUT THIS INFORMATION

WE WILL SET UP THE APPOINTMENT WITH THE CONTACT PERSON UNLESS SPECIFIED OTHERWISE. THANK YOU.