North Simcoe Muskoka
Specialized Geriatric Services

NSM Specialized Geriatric Services Program
Central Intake Referral Form

Phone: 705-417-2192 / Fax: 705-792-4614

* We do NOT provide emergency or crisis services
* Incomplete referral information will delay referral processing
* Please fax completed referrals to 705-792-4614
* Questions? Please call Central Intake at 705-417-2192

Name of Patient: _____ (First name) _____ (Surname) **Telephone #:** _____

Address: _____ (Street Name and Number) _____ (Apt.) _____ (City) ON (Prov) _____ (Postal Code)

Health Card #: _____ (Version Code) **DOB:** _____ (dd/mm/yyyy) **Translator required:** ☐ **Yes** ☐ **No** _____ (Language)

French Language Services Requested: ☐ Yes ☐ No **Aboriginal Origin:** ☐ Aboriginal Self-Identified ☐ Non-Aboriginal ☐ Unknown

Living Situation: ☐ **Lives alone** ☐ **With spouse/caregiver** ☐ **Other-specify** **Gender:** ☐ **M** ☐ **F** ☐ **Other-specify**

Submission of this referral form will be taken to explicitly mean that you have obtained appropriate permissions for NSM SGS program to collect, use and disclose personal health information (PHI) with circle of care health service providers to assist with the care of the referred patient. NSM SGS program will assess the needs of the referred patient and may direct referrals to a different service than requested based on the information gathered.

Patient able to provide consent for collection/use/disclosure of PHI: ☐ **Yes** ☐ **No** **Patient aware of referral?** ☐ **Yes** ☐ **No**
If no, provide Substitute Decision Maker (SDM) information as Alternate Contact.

Contact Person for Booking Appointment: ☐ **Patient** ☐ **Alternate Contact - Reason:** _____

Alternate Contact: _____ **Relationship:** ☐ **SDM** ☐ **Other** _____ **Tel #:** _____

SERVICE REQUESTED

The NSM SGS program provides services to older adults residing in and able to access services in the NSM region.
NOTE: Requests for Geriatric Psychiatrist/Geriatrician require a physician or nurse practitioner referral.

☐ **Geriatric Medicine Team**
Geriatric medicine services support frail older adults with geriatric syndromes who would benefit from a comprehensive geriatric assessment by an interprofessional team with specialized knowledge/skills in geriatric medicine. Services vary in each region based on available resources, including access to Geriatricians.
Where formal partnerships exist, the NSM SGS program will automatically redirect Geriatric Medicine referrals to the sub-region team in which the patient resides.

☐ **Geriatric Mental Health Team**
Consultation services for seniors in the community or LTCH with a diagnosis of serious mental illness for treatment recommendations **and/or** experiencing expressive/responsive behaviour as a result of a cognitive impairment that can be related to dementia, mental illness, addictions and/or other neurological disorders.

☐ **Seniors CARE Exercise Program**
A group exercise rehabilitation program delivered by Registered Kinesiologists targeting frail older adults offered in partnership with local agencies in Barrie, Couchiching and North Simcoe. This program is offered 2 times/week for 10-12 weeks with a focus on balance, coordination and upper and lower extremity strengthening as well as health education and cognitive stimulation.
☐ As the referring MD/NP, I confirm this individual is medically clear to participate in the CARE program.

☐ **GeriMedRisk Consult**
An interdisciplinary team with expertise in pharmacy, geriatric psychiatry, clinical pharmacology and geriatric medicine that provide support in managing medication/physical/mental health issues in older adults. GeriMedRisk specialist physicians do not see the patient over phone or video, but rather provide recommendations based on the information provided. Where appropriate, GeriMedRisk conducts a best possible medication history via phone with the patient/caregiver. Written response received within a median of 5 business days.

☐ **Unsure, help me find the best service**

To expedite the referral please include (required for Geriatric Medicine Team):**

☐ **Blood Work: CBC, Lytes, Bun, Cr, Ca, Mg, Phos, TSH, Alb, B12, Ferritin	☐ **Diagnostic Tests – ECG and CT Head if concerns of cognitive impairment	☐ Results of previous cognitive and/or functional tests
☐ Cumulative Patient Profile (CPP)	☐ Consult Note(s)/ Specialist Report(s)	☐ Current medication list

If there is no ECG/CT Head, please arrange prior to appointment.

Waypoint
CENTRE for MENTAL HEALTH CARE
CENTRE de SOINS de SANTÉ MENTALE

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Patient Name: _____

SYMPTOMS / CONCERNS IDENTIFIED (Check all that apply)	New or Recent Decline	**PRIMARY REASON FOR REFERRAL:** *What is the main concern to be addressed? If Responsive behaviours – please describe. If new or recent decline – please describe.*
☐ **Mobility/ falls**	☐ Yes	
☐ **Incontinence**	☐ Yes	
☐ **Pain management**	☐ Yes	
☐ **Medication/ polypharmacy**	☐ Yes	
☐ **Sleep disturbance**	☐ Yes	
☐ **Weight loss /nutrition**	☐ Yes	
☐ **Parkinsonism**	☐ Yes	
☐ **ADL/ IADL decline**	☐ Yes	
☐ **Cognitive changes/ dementia**	☐ Yes	
☐ **Atypical cognitive changes**	☐ Yes	
☐ **Responsive behaviours** ☐ **Escalating physical response** ☐ **Other** _____	☐ Yes	
☐ **Delusions/ hallucinations**	☐ Yes	
☐ **Suicidal/ homicidal ideation**	☐ Yes	
☐ **Anxiety/ mood concerns**	☐ Yes	
☐ **Psychotic Symptoms**	☐ Yes	
☐ **Caregiver/ family concerns**	☐ Yes	
☐ **Elder abuse/neglect suspected**	☐ Yes	
☐ **Social isolation**	☐ Yes	
☐ **Recurrent ED visits**	☐ Yes	
Other (specify):	☐ Yes	

Referral Location: ☐ Primary Care ☐ HCCSS-NSM ☐ Hospital ☐ ED ☐ Community Support Service ☐ LTCH ☐ Retirement Home

Referral Source: ☐ Physician ☐ Nurse Practitioner ☐ Self ☐ Other:

_____
Organization Name

Name of Person Referring: _____

Contact Numbers: _____ _____
Tel # *Fax #*

Referral signature: _____ **Date (dd/mm/yyyy):** _____

Primary Care Practitioner Name: _____ **Billing #** _____

Contact Numbers: _____ _____
If different from above *Tel #* *Fax #*

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