REFERRAL FORM: Specialty Clinics/Outreach/BSO

Centre for Healthy Aging
Hamilton Health Sciences
St Peter's Hospital Site
88 Maplewood Ave. Hamilton, ON L8M 1W9
Phone: 905 521 2100 x12397 Fax: 905 549 7003

St. Peter's Hospital
Centre for Healthy Aging

Patient Name: Address: City, Postal Code: Telephone: Date of Birth: HIN & Version: **Contact Person:** Telephone:	☐ Urgent (reason) _____ ☐ Non-Urgent Interpreter Needed: ☐ Yes Language: _____ Living Arrangement: ☐Alone ☐House ☐Family ☐Apartment Supportive Living or Long Term Care Home: Facility Name:_____

Reason(s) For Referral (please check as many as apply)

☐ Agitation	☐ Acute Confusion	☐ Behavior Changes	☐ Caregiver Burden/stress	☐ Delusions
☐ Depression	☐ Dementia	☐ Elder Abuse	☐ Failure to Thrive	☐ Falls / Instability
☐ Hallucinations	☐ Incontinence	☐ Memory Impairment	☐ Mania	☐ Osteoporosis
☐ Parkinson's	☐ Physical Decline	☐ Poly-Pharmacology	☐ Risk To Others	☐ Spasticity
☐ Suicidal	☐ Weight Loss	☐ Wandering/Exit seeking	☐ Substance Abuse	

Primary Concern :

_____

_____

_____

Specialty Required: ☐ Medicine ☐Psychiatry ☐ Osteoporosis/Fractures ☐ Behavioural Supports Ontario (BSO) ☐ Physiatry

The Following Information Must Accompany the Referral:

- Medical History/ Psychiatric History
- Recent Hospitalization or ED visit ☐Y ☐N If Yes, include discharge summaries from other than HHS
- Recent Laboratory Results (within last year)
- Recent/Relevant Investigations *(eg. ECG, CT, MRI,)*
- Results of any Cognitive Testing *(e.g. MMSE, MoCA)*
- Has the patient been seen by another geriatric service? ☐Y ☐N Specify _____
- Medications (send list or MARs or record on lines below)

  _____
- Allergy/Drug Intolerance (list) _____
- Has Patient received services at HHS- SPH in the past? ☐Y ☐N Specify _____

Referral Source: Contact Information

Patient/Family is aware of this referral ☐Y ☐N

Family Physician Name if Other Than Referral Source _____
Phone # _____ Fax #_____
Address Address

Family Physician agrees to this patient being referred to therapy services within the Centre for Healthy Aging if needed. ☐ Y ☐ N
Family Physician agrees to this patient being referred to Behavioural Supports Ontario team if needed. ☐ Y ☐ N

Physician Signature: _____ Date _____

Appointment Date:_____ **Patient will be contacted by Family Doctors office with appointment date**