Central Intake
Seniors' Services – Trillium Health Partners
Tel: (416) 521-4090
Fax: (416) 521-4116

Trillium Health Partners

OFFICE USE ONLY: Date Received *(dd/mm/yy)*: _____
Date Reviewed *(dd/mm/yy)*: _____ ID#: _____

Seniors' Services Referral Form

PLEASE COMPLETE ALL FIELDS AND SIGN THE FORM.
MISSING OR INCOMPLETE INFORMATION WILL DELAY PROCESSING OF REFERRAL.

Name of Client: _____ ☐ M ☐ F
Surname *First Name*

Address: _____
Street Number and Name *Apartment* *City* *Province* *Postal Code*

Phone: _____ Marital Status: _____

Health Card #: _____/_____/_____ _____ Date of Birth: _____
Version Code *DD / MM / YYYY*

Person to contact re booking appointment: _____ Phone *(daytime)*: _____

Relationship to client: _____ Phone *(evening)*: _____

Is CCAC involved? ☐ no ☐ yes ☐ unsure

Does the client have a Substitute Decision Maker or Power of Attorney? ☐ unsure ☐ no ☐ yes (complete information below if different from above)

Name: _____ Phone *(daytime)*: _____ Phone *(evening)*: _____

Reason for Referral (check all that apply):

☐ Functional Decline
☐ Cognitive Impairment
☐ Medication Management/ Polypharmacy
☐ Psychosocial
☐ Incontinence
☐ Constipation
☐ Weight Loss/Nutrition
☐ Falls
☐ Other (specify): _____

Main Concern(s) to be addressed: _____

Indicate the service of preference (check all that apply):

☐ **Geriatric Assessment Clinic:** *Assessment with MD and/or Nurse Practitioner*
☐ **Falls Prevention/Bone Health Program:** *Consultation with MD and/or NP and PT and 6 week exercise/education program; client must be able to walk 25 m and learn new information.*
☐ **Regional Continence Clinic *(Nurse led)*:** *assessment and education*
☐ **Regional Continence Home Visits (Nurse led):** *assessment and education for moderately to severely housebound frail seniors*
☐ **Regional Geriatric Medical Outreach:** *In home medical/physical, cognitive, functional and psychosocial consultation by inter-professional team; If client is not housebound, specify why reason home visit required:* _____

Medical History: ☐ See Attached

Medications: Please attach medication profile and recent lab results less than 3 months.

Infection Control: Has the client ever had any of the following infections (check all that apply)?
☐ MRSA ☐ VRE ☐ c. Difficile ☐ TB ☐ ESBL

Referral from: ☐ Emergency Dept ☐ Acute Care ☐ Primary Healthcare ☐ Other _____

Name of Family MD *(please print)*: _____ Phone: _____ Fax: _____

Name of Referring MD *(please print)*: _____ Phone: _____ Fax: _____

Signature of Referring MD: _____ OHIP Billing #: _____ Date *(dd/mm/yy)*: _____

OFFICE USE ONLY:

Please fax with relevant notes, recent lab results and/or ECG. # of pages being faxed: _____

****We will contact your patient directly after receiving this consult request. Thank you.**