

NSM SPECIALIZED GERIATRIC SERVICES PROGRAM Central Intake Referral Form

Marco NOT provide emergency or crists services	KEY INFORMAT	ION		
Client / Patient Information	 We do <u>NOT</u> provide emergency or crisis services 	AX completed referrals to 705-792-4614		
Lost Name (please print): First Name (please print):	Only fully completed referrals will be processed G	 Only fully completed referrals will be processed Questions? Call SGS Intake Service 705-417-2192 		
First Name (please print): DOB (dat/mm/yyyy): Address: Health Card (HC)#: City/Town: Postal Code: HC Province: Preferred Language: Interpreter Required: Yes No	Client / Patient Info	rmation		
DOB Class Health Card (HC)#:	Last Name (please print):			
Address:				
City/Town: HC Version Code: Postal Code: HC Province: Telephone #: Alternate Phone #: Preferred Language: Interpreter Required: Yes No Aboriginal Self-Identified Non-Aboriginal Unknown Living Situation: Lives Alone With Spouse / Caregiver(s) Other (please identify): Cilent Aware of Referral: Yes No Key Contact Information For appointment set up Who should we contact to gather additional information and book an appointment? Patient SDM Other (please identify): Primary Contact Name: Telephone #: Can we leave a voicemail? Yes No Relationship: Spouse Chilid Friend Other (please identify): Any additional information about contacting the patient or key contact that we should know? Referral Source Information Name of Referring Source (please print): Physician Nurse Practitioner Billing #: Self Other (please identify): NAM SGS Program Retirement Home ACE Unit Other (please identify): Primary Care ED CCP Unit CSS Hospital Telephone #: Referral signature: Patient Signature: Patient Other (please identify): Patient Signature: Patient Signature: Patient Signature: Patient Signature: Patient Signature: Primary Practitioner Name (please print): Primary Care practitioner Not the referring source Primary Practitioner Not the referring source Primary Practitioner Name (please print): Primary Practitioner Not the referring source Primary Practitioner Name (please print): Primary Practitioner Not the referring source Primary Practitioner Name (please print): Primary Practitioner Not the referring source Primary Practitioner Name (please print): Primary Practitioner aware of referral ?:				
Postal Code:				
Preferred Language: Interpreter Required: Yes No Aboriginal Self-Identified Non-Aboriginal Unknown Living Situation: Lives Alone With Spouse / Caregiver(s) Other (please identify): Client Aware of Referral: Yes No Key Contact Information For appointment set up Who should we contact to gather additional Information and book an appointment? Patient SDM Other (please identify): Primary Contact Name: Telephone #: Can we leave a voicemail?: Yes No Relationship: Spouse Child Friend Other (please identify): Any additional information about contacting the patient or key contact that we should know? Referral Source Information Name of Referring Source (please print): Physician Nurse Practitioner Billing #: Self Other (please identify): Name of Referring Agency (please print): Primary Care LTCH CCC Unit Other (please identify): Referral signature: Date (dd/mm/yyyy): Submission of this referral form will be taken to explicitly mean that you have obtained appropriate permissions for releasing the information *Contained in this referral form to the NSM SGS program. If applicable, please include your organization's Consent to Release of Personal Health Information Form. Primary Care Practitioner Information To be completed if primary care practitioner sware of referring source Primary Practitioner Name (please print): Primary Practitioner aware of referral ?:				
Interpreter Required: Yes No	· · · · · · · · · · · · · · · · · · ·	Alternate Phone #:		
Aboriginal Origin: Aboriginal Self-Identified Non-Aboriginal Unknown Living Situation: Lives Alone With Spouse / Caregiver(s) Other (please identify): Client Aware of Referral: Yes No Key Contact Information For appointment set up Who should we contact to gather additional information and book an appointment? Potient SDM Other (please identify): Primary Contact Name: Telephone #: Can we leave a voicemail?: Yes No Relationship: Spouse Othild Friend Other (please identify): Any additional information about contacting the patient or key contact that we should know? Referral Source Information Name of Referring Source (please print): Self Other (please identify): Name of Referring Agency (please print): Other (please identify): Name of Referring Agency (please print): Other (please identify): Primary Care Other (please identify): Date (add/mm/yyyy): Submission of this referral form will be taken to explicitly mean that you have obtained appropriate permissions for releasing the information occanent to Release of Personal Health Information Form. Primary Care Practitioner Information To be completed if primary Practitioner NOT the referring source Primary Practitioner Name (please print): To be completed if primary Practitioner aware of referral?:		French Language Services Requested:		
Living Situation: Lives Alone With Spouse / Caregiver(s) Other (please identify): Client Aware of Referral: Yes No Key Contact Information *For appointment set up				
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Relationship: Spouse				
Referral Source Information Name of Referring Source (please print): Physician Nurse Practitioner Billing #: Self Other (please identify): Name of Referring Agency (please print): NSM SGS Program Retirement Home ACE Unit Other (please identify): Primary Care LTCH CCC Unit HCC ED CCP Unit GSS Hospital Telephone #: Fax #: Referral signature: Date (da/mm/yyyy): Submission of this referral form will be taken to explicitly mean that you have obtained appropriate permissions for releasing the information contained in this referral form to the NSM SGS program. If applicable, please include your organization's Consent to Release of Personal Health Information Form. Primary Care Practitioner Information To be completed if primary care practitioner NOT the referring source		Can we leave a voicemail?: Yes No		
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Physician Nurse Practitioner Billing #: Self Other (please identify):				
Name of Referring Agency (please print): NSM SGS Program	I — " " " " " " " " " " " " " " " " " "			
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Please FAX completed referrals to SGS Central Intake at 705-792-4614



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	North Simcoe Mus		
-	Specialized	Geriatric	Services
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Referral information				
Patient Name:	NOTE:			
Primary Reason for Referral:	 See following pages for service descriptions/ eligibility criteria. NSM SGS program reserves the right to engage other NSM SGS service(s) as appropriate to meet the patient's needs Requested NSM SGS Service: 			
Referral Information: Why are you referring now? What has changed? Please provide as much detail as possible about the reason for referral:				
	Geriatric Medicine: Integrated Regional Falls Program (IRFP)			
	Geriatric Mental Health: Behaviour Support System (BSS) * For Waypoint's Geriatric Psychiatry Community Consultation Service (formerly GPOT) or Horizon Inpatient Unit refer ONLY via Waypoint's Central Intake www.waypointcentre.ca/referrals or 705-549-3181 x 2308			
	Classroom Programming: Seniors CARE Exercise Program As the referring MD/NP, I confirm this individual is medically clear to participate in the program * Medical clearance required for participation			
Risks: No risks from this list are present Cognitive impairment/poor insight Difficulty walking/transferring or recent falls Five or more medications Emergency Department (ED) use in the last 30 days or hospitalization(s) in the last 90 days Risk of harm to self (suicidal, self-neglect)	Level 1 Consult: GeriMedRisk * GeriMedRisk ALSO accessible via OTNhub eConsult service ("GeriMedRisk/ Geriatric Clinical Pharmacology" or "Geriatric Medication Provincial Group" specialty groups) or by calling 1-855-261-0508.			
Risk of harm to others (homicidal ideation, physical aggression) Risk of harm from others (due to responsive behaviour) Risk of abuse (neglect, emotional, physical) Substance Abuse (alcohol, smoking or other substances that places individual's safety at risk)	Other Available NSM SGS Services: • Level 1 Consult: Complex Case Resolution (CCR) * Refer ONLY via phone to SGS Central Intake - 705-417-2192			
If available and appropriate, please attach the following information to help inform the referral: Consult Note(s) / Specialist Report(s) Results of previous cognitive and/or functional tests Recent labs / Diagnostic Imaging Current medication list Other (please identify):	Level 1 Consult: NSM SGS Specialist eConsult Service * Refer ONLY via OTNhub eConsult service ("North Simcoe Muskoka Specialized Geriatric Services" specialty group).			

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