Capital Health

**Community Geriatric Navigator**

# Referral Form

Dartmouth General Hospital
Telephone (902) 465-8446
Fax# (902) 465-3567

CLIENT NAME: ________________________ DATE: (yyyy/mm/dd) ________________
DOB: (yyyy/mm/dd) ________________ Client's HC#: ________________ GENDER: M / F
CURRENT HOME ADDRESS: ________________________________________
POSTAL CODE: ____________ PHONE: ________________

PRIMARY REASON FOR THE REFERRAL (i.e. What do you want us to help with?): ________________
________________________________________
________________________________________
________________________________________

REFERRAL REQUEST:
- ☐ Routine (able to be placed on a waitlist for service)
- ☐ Priority (needs to be contacted with in 5 working days)
- ☐ Urgent (needs to be contacted ASAP)

PRIMARY DIAGNOSIS: ________________________________________
________________________________________
________________________________________
________________________________________

RISK FACTORS:
- ☐ Has a history of cognitive impairment
- ☐ Has had recent falls or difficulty walking
- ☐ Has been to emergency in the past 30 days or hospitalization in the past 90 days
- ☐ Is on more than 5 medications
- ☐ Lives alone or has no available caregiver
- ☐ Change in caregiver status/caregiver burn out

OTHER MEDICAL INFORMATION: ________________________________________

CURRENT LIVING STATUS:
☐ Living in community ☐ Alone ☐ With formal supports ☐ With informal supports
☐ Being discharged home Expected discharge date ________________________

PROFESSIONALS / AGENCIES CURRENTLY INVOLVED WITH CLIENT (if known): ________________
________________________________________

PERSON TO CONTACT: *(If primary contact is someone other than client please obtain consent from client and indicate on referral).*
☐ Client ☐ Other Name: ________________________________
Relationship ________________ Phone: ________________

IS CLIENT AWARE OF REFERRAL TO COMMUNITY GERIATRIC NAVIGATOR? Y / N
FORM COMPLETED BY: ________________________ PHONE: ________________
SIGNATURE: ________________________________
PROGRAM/SERVICE/PROFESSIONAL DESIGNATION: ________________________________

**Referral Forms**