nova scotia health authority

Geriatric Ambulatory Care

Referral Form

Phone: (902) 473-4822 Fax: (902) 473-7133 Centre for Health Care of the Elderly

1. Name: _____ Mr ☐ Mrs ☐ Ms ☐ Miss ☐
   Address: _____
   Town/City: _____
   Phone #: _____ Is patient aware of referral? YES ☐ NO ☐
   DOB: (YY/MM/DD) _____ HCN: _____

2. Contact person(s): _____ Phone #: _____

3. Referring physician: _____ Phone #:_____Fax #:_____

4. Reason for Referral: _____
   _____

5. **FOR MEMORY ASSESSMENTS:** Attach MMSE and lab results (CBC, electrolytes, glucose, urea, creatinine, calcium, TSH, vitamin B12) within the past 3 months.

6. Past Medical History: _____
   _____
   _____
   _____
   _____

7. Medications: _____
   _____
   _____
   _____
   _____

8. Living Arrangements
   ☐ Lives Alone ☐ Lives With Spouse
   ☐ Lives with Family Members ☐ Lives Alone with Supports (i.e. Home Care)
   ☐ Other Living Arrangements (describe) _____

9. Other Consultants presently seeing patient ☐ Neurology ☐ Psychiatry ☐ Psychology ☐ Other

10. Referral Request
    ☐ Routine (more than two weeks)
    ☐ Urgent
    ☐ Telephone Consult

11. Please enclose any additional information which may be pertinent to the assessment of your patient.

12. Has the patient been assessed by a geriatrician previously? If so, please indicate which physician _____.

Please note that Geriatric Medicine and Seniors Mental Health offer services that may overlap. To avoid duplication or potential delays, please select the service most appropriate to meet the needs of your patient.