Primary Care Network CAMROSE

CAMROSE | BASHAW | DAYSLAND
FORESTBURG | HARDISTY

Last Name _____ First Name _____

PIN _____ Gender _____

Address _____

_____

DOB _____ Home Phone _____

Work Phone _____ Cell _____

Geriatric Assessment Program (GAP) - ≥ 65yrs of age
Referral Form

Phone: 780.608.4927
Fax: 780.608.4931

Date of Referral _____Referral Physician _____

Family Physician _____ Phone _____ Fax _____

Date of next follow-up appointment with Physician (if any) _____

Patient Location □ Home □ Lodge □ DAL □ Continuing Care □ Hospital

Next of Kin:_____ Contact Info_____

Personal Directive/Guardianship □ Yes □ No Name_____

Contact Info _____

Is the patient/guardian aware of this referral and given consent □ Yes □ No

Is this a homecare patient □ Yes □ No

Please ensure the following investigations are current to within 3 months of referral date:

- □ Albumin, ALP, ALT, AST, Calcium, Creatinine, Electrolytes, Glucose-random, Magnesium, Urea, Vitamin B12, CBCD, TSH
- □ Medication profile
- □ Other relevant information not available on NetCare

Refer to: **(NOTE – no transfer of care will occur)**

□ **Fall Prevention Program – ***if multiple concerns or cognitively impaired refer to the GAP program (see below)
- □ 2 falls in 12 months
- □ 1 fall plus balance, mobility concerns
- □ 1 injurious fall

□ **Geriatric Assessment Program** for
- □ Assessment only
- □ Assessment and therapeutic short-term management

Reason for referral: (i.e. frequent falls, signs of memory loss/dementia, urinary incontinence, decreased mobility, difficulty coping, comprehensive med review/complex health concerns etc)

PHYSICIAN SIGNATURE: _____

Revised Sept 2017