



Last Name _____ First Name _____

PIN _____ Gender _____

Address _____

DOB _____ Home Phone _____

Work Phone _____ Cell _____

**Geriatric Assessment Program (GAP) - \geq 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-enacted Yes No Name of Agent / contact #- _____

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, HgbA1c, 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 Aug 2022