

## Specialized Geriatric Services Intake/Referral Form Tel: (519) 685-4046 Fax: (519) 685-4020

Mailing Address: 801 Commissioners	Road East, London	ON N6C 5J1				
What service does this client	require?					
☐ Musculoskeletal Unit	□ Reg	gional Geriati	ic Program Outreach		riatrician Consult	
☐ Geriatric Rehabilitation Unit ☐ Regional Psychogeriatric Program Outreach ☐ Geri					iatric Day Hospital	
☐ Aging Brain & Memory C	linic 🗆 GI	OH – Parkins	on's Education Program			
☐ Geriatric Mental Health (I	☐ Consult only ☐ Home Visit			//spousal assess	sment)	
If patient is in hospital or I			,			
Facility: Date of Admission:						
Address/Unit: Phone #:						
Last Name:		]		Sex: □ M		Marital Status
Street Address:		City:			Postal Code:	
Telephone #: Date of Birth (yy-mm			m-dd): OHC# (+ version code):		Language: ☐ English ☐ Other:	
Contact Person:         Name:						
Name:			Home #:	Wo	ork #:	
Reasons for referral: (list & in	clude recent cha	nges)				
PLEASE ATTACH:						
MEDICAL/PSYCHIAT		RY • MEI	DICATION LIST • LA	B RESULTS	S • RELE	CVANT
CONSULTS • ANY AL		_				
If Geriatric Mental Hea	-	-	_			
Type of Substance Abu					a4: a	
Other Concerns eg. Par Family Physician	anoia, deiusi	ons, safety	, dementia, finances, fa	mily dystun	cuon	
Talling Filysician					Date of Re	ferral:
Telephone: Fax:						
Physician authorization of Res	ferral					
					(yy-n	nm-dd)
(Print Name)			(Signature)			