MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Geriatric Urgent Care Referral Form

Tel: (416) 469-6031 Fax: (416) 469-6458

REF

Patient Label

Caregiver Information:		Relationship to Patient:
Caregiver Last Name:	Caregiver First Name:	Caregiver Phone Number:

Who should we contact about the appointment?
☐ Patient *(Note: Patients must bring their caregiver or family member to the appointment)_*
☐ Caregiver
☐ Both

What number(s) can we use to contact you about your appointment?
1. ( )
2. ( )
3. ( )

Can we leave a message? ☐ Yes ☐ No

Does the patient speak English? ☐ Yes ☐ No

If No, what language? _____

Clinical Information:

IMPORTANT
PLEASE READ:

INCOMPLETE REFERRALS WILL BE RETURNED FOR COMPLETION

PLEASE SEND:

- **ALL PERTINENT DIAGNOSTIC & LAB RESULTS**
- **LIST OF CURRENT MEDICATIONS**
- **CONSULTNOTES / DISCHARGE SUMMARY**

Referral Criteria:
Patients with one or more of the following active geriatric syndromes, in which primary care providers are unable to manage in the community, where primary care provider has deemed patient to be at high risk for readmission/ED visit.

Geriatric Syndromes: Please specify

☐ 1. Cognitive impairment
☐ 2. Behavioral difficulties related to dementia
(Note: Patients < 65 years old can be referred for cognitive impairment/dementia)
☐ 3. Falls or mobility issues
☐ 4. Polypharmacy
☐ 5. Caregiver strain
☐ 6. Functional decline
☐ 7. Frailty

Referral Source: Please specify *(Note: * ER referrals should be scheduled within 2 weeks)*

☐ MGH Hospitalist or Internist – ER Patient*
☐ MGH Geriatric Emergency Management Nurse*
☐ MGH Geriatrician IP Discharge Follow-up
☐ New Patient Community/Family Physician Referral

Has the patient been to the Emergency Department within the last 6 months? ☐ Yes ☐ No

Reason For Referral:

_____

_____

Referring Physician:	Physician Name:		Telephone Number: ( )
	Referring Clinic Name:		Fax Number: ( )
	Physician's Signature:	Billing#:	Date:

Appointment:	