HURON PERTH GERIATRIC SERVICES INTEGRATED REFERRAL FAX:519-527-8420 PHONE:519-527-8421 ext.4818

Intake & access of referrals are managed by Huron Perth Healthcare Alliance. All listed organizations may receive the patient's personal health information as necessary to determine the most appropriate geriatric service(s), in compliance with the Personal Health Information Protection Act (PHIPA)

- Seniors Mental Health, Huron Perth Healthcare Alliance (Behavioural Supports Ontario Mobile Team)
- Geriatrician – Dr. Alexandrea Peel & Listowel Wingham Hospitals Alliance
- Alzheimer Society Huron Perth
- Huron Perth Geriatric Resource Nurses (GRNs), St. Joseph's Health Care London

Date of referral:

PATIENT INFORMATION

Last name	First name	Age	Pronoun:	Language:

Address:	Phone # 1: Phone # 2:	Patient/SDM consent for referral? Yes ☐ No ☐

Health card (including version code)	Date of birth: YYYY/MM/DD	**Person to contact:** ☐ Patient ☐ Alternate contact

ALTERNATE CONTACT

Name:	Relationship to patient:	Is the alternate contact the SDM? Yes ☐ No ☐ Unsure ☐	Phone number:

PRIMARY REASONS FOR REFERRAL (check all that apply)

☐ Memory concerns/cognition/personality change
☐ Medical complexity & frailty
☐ Mental health assessment/psychiatry
☐ Medication review/polypharmacy
☐ Mobility & falls/functional decline
☐ Movement disorders (e.g. Parkinsonism)
☐ Driving concerns
☐ Caregiver support/education & dementia resources
☐ Responsive behaviours with dementia, mental health addictions (BSO) - **specify behaviours:**

☐ Local memory clinic assessment?
Yes ☐ No ☐ **PLEASE ATTACH MOST RECENT**

☐ Home visit REQUIRED **(specify why):**

☐ ACTIVE Safety concerns **(specify):**
☐ ACTIVE Risk of harm to self/others:
☐ Recurrent hospitalizations/ED visits:

PRIMARY CLINICAL QUESTION/CONCERN

WHAT MATTERS MOST TO YOUR PATIENT?

☐ **ATTACH - to assist with timely review of referral: please include** ALL previous memory clinic recommendations, including copies of cognitive/mood testing, health history & medication list, all initial work-up - relevant labs, imaging

REFERRAL SOURCE

Name (PRINT):

Name of Organization (eg.FHT, OHaH, CMHA)

Contact #:

Primary Care Provider (if not referrer)**:**

Physician/Nurse Practitioner SIGNATURE

x_____
If verbal order, taken by:

Office Address:

Phone: | Fax:

Billing number:

In partnership with regional geriatric services, we provide navigation support to additional geriatric services not available locally. If your patient requires access to additional ambulatory geriatric services not available locally, the referral will be automatically forwarded to the geriatric service by the Huron Perth Healthcare Alliance. Huron Perth Healthcare Alliance will notify the referring provider if this occurs.