



Geriatric Day Hospital REFERRAL FORM

Phone: (902) 473-2493 Fax: (902) 473-7336

Please print clearly and complete all sections.

Falls Referral
 Regular Referral
 Letter Attached

Name: _____
 Address: _____
 Phone #: _____ Date of Birth (YYYY-MM-DD): _____
 Health Card #: _____ Expiry: _____
 Referral Source: _____ Phone #: _____ Fax #: _____
 Family Physician: _____ Phone #: _____ Fax #: _____
 Contact for Initial Appt: _____
 Home Phone #: _____ Cell / Work #: _____

Specific Reason for referral / description of falls:

Medical Problems	Associated Medications



Current Functional Information				
Mental Status	<input type="checkbox"/> Normal	<input type="checkbox"/> Impaired	MMSE	/ 30
Emotional	<input type="checkbox"/> Normal	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Other
Communication	<input type="checkbox"/> Normal	<input type="checkbox"/> Impaired		
Mobility	Transfers	<input type="checkbox"/> Independent	<input type="checkbox"/> Assisted	<input type="checkbox"/> Unable
	Walking	<input type="checkbox"/> Independent	<input type="checkbox"/> Assisted	<input type="checkbox"/> Unable
	<input type="checkbox"/> Aids _____			
Balance	<input type="checkbox"/> Normal	<input type="checkbox"/> Impaired	<input type="checkbox"/> Falls # _____	
Bowel / Bladder	<input type="checkbox"/> Continent	<input type="checkbox"/> Incontinent		
Nutrition	Weight _____ lbs	<input type="checkbox"/> Stable	<input type="checkbox"/> Loss	<input type="checkbox"/> Gain
Activities of Daily Living	<input type="checkbox"/> Independent	<input type="checkbox"/> Assisted	<input type="checkbox"/> Unable	
Social	<input type="checkbox"/> Lives alone	<input type="checkbox"/> Lives with other: _____		
Main Social Support	<input type="checkbox"/> Family	<input type="checkbox"/> HCNS/CCNS	<input type="checkbox"/> Other	

Patient's Family Physician has been contacted and is aware of AND agrees with referral to the Geriatric Day Hospital/Falls Clinic. *In the interest of integrated patient care, the patient's Family Physician must be notified of this referral by phone or by faxing a copy of this referral form to the family physician. Thank you for your attention to this.*

Signature (Physician signature is required for MSI purpose) _____	
Name (Please Print) _____	
<i>(If trainee, please provide attending MD name)</i>	
Date (YYYY-MM-DD): _____	Date Received (YYYY-MM-DD): _____

Who is Eligible to Attend Falls Clinic?

Persons who:

- are 65 years or older
- have had one or more falls
- OR
- have had mobility or balance problems
- agree to be assessed by the Falls Clinic staff
- are able to take part in an exercise program

Please note - patient must be able to attend a 2 hour session twice weekly for 6-8 weeks