Geriatric Medicine
OUTPATIENT SERVICES REFERRAL FORM

Phone: 902-473-4822 Fax: 902-473-7133

Date (YYYY/MON/DD): ____________________

1. **Patient Information:**

   Name: ____________________ DOB (YYYY/MON/DD): ____________________

   Phone #: ____________________ HCN: ____________________

   Address: ____________________

2. **Referring Healthcare Provider:** ____________________

   Phone #: ____________________ Fax #: ____________________

   ❑ I acknowledge that Geriatric Medicine uses a central triage model, the referral will be triaged to the most appropriate service, and provider, who may not be a geriatrician.

   ❑ I would accept a 'Provider to Provider" telephone consult, as an alternative to a standard consult.

3. **Reason for Referral:** ____________________

4. **If the purpose of the consult is to evaluate COGNITION, please complete the following checklist:**

   ❑ Cognitive deficits affecting daily function

   ❑ I have attached MMSE (Mini-Mental State Examination) Score and date completed.

   ❑ I have attached or arranged bloodwork: Electrolytes, Creatinine, TSH, Calcium, B-12.

   ❑ I acknowledge that Geriatric Medicine requires someone who knows the patient well to accompany them to the clinic to provide additional information and to be contacted regarding the appointment time.

   Name of contact: ____________________

   Relationship to patient: ____________________

   Contact's phone number: ____________________

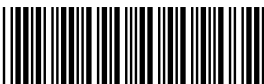
5. **Living Arrangements:** ❑ Alone ❑ With spouse ❑ With family ❑ Facility/other: ____________________

6. **Past Medical History:** ____________________

7. **List or attach medications:** ____________________

8. **If urgent referral required, please explain:** ____________________

9. **Has the patient been previously assessed by a geriatrician? If so, please indicate which physician:** ____________________



Please note that Geriatric Medicine and Geriatric Psychiatry offer services that overlap.
To avoid duplication, please consult only one service at a time.