



**REFERRAL FORM**  
**Geriatric Day Hospital**

Date:

Last Name:

Given Name:

Gender:  M  F OHIP No.:

Version Code:

Date of Birth:

Address:

City:

Postal Code:

Tel. (home):

Marital Status:  Single  Common-Law  Married  Separated  Divorced  Widowed

Contact Person:

Relationship:

Address:

City:

Postal Code:

Tel. (home):

**Reason for Referral**

Mobility/Transfers

Function (Activities of Daily Living)

Falls

Cognitive Issues that are Affecting Function

Instrumental (Activities of Daily Living)

Care Giver Stress

Mood Issues Affecting Function

Polypharmacy or Medication Management

**Referral Source**

Last Name:

Given Name:

Organization/Institution:

OHIP Billing No.:

Phone No.:

Fax No.:

**Check Appropriate Boxes**

Lives Alone  No Family/Friend Support

Receives Home Services

— Please specify:

Concerns Regarding Driving

**If the Ministry of Transportation has been notified please indicate the date:**

**Past Medical History (Please Attach Cumulative Patient Profile)**

I have discussed the commitment of attending the day hospital program twice a week that can last up to 10 weeks and patient has agreed to attend if accept.

Patient Name:

DOB:

**Please attach all relevant bloodwork and/or other investigations**

	Attached	N/A		Attached	N/A
<input type="checkbox"/> CT head/other:			<input type="checkbox"/> ECG:		
<input type="checkbox"/> MRI head/other:			<input type="checkbox"/> Blood work:		
<input type="checkbox"/> X-ray:			<input type="checkbox"/> BMD:		
			<input type="checkbox"/> Other:		

**Medications:**

- |     |     |
|-----|-----|
| 1)  | 11) |
| 2)  | 12) |
| 3)  | 13) |
| 4)  | 14) |
| 5)  | 15) |
| 6)  | 16) |
| 7)  | 17) |
| 8)  | 18) |
| 9)  | 19) |
| 10) | 20) |

Community  
Pharmacy Name:

Allergies to Medication:

Other Allergies (food, environmental):

**Additional Information:**

**Patients will NOT be given an appointment until we have the information requested above.**

**Send to Geriatric Day Hospital  
75 Bruyère St., Ottawa ON K1N 5C8  
Fax: 613-562-4265**