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Geriatric Assessment Program Referral

Geriatric Assessment Program
Greater Niagara General Site
Allied Health Building
5672 North Street
Niagara Falls, ON L2G 1J4

Referral Date: _____ (dd/mm/yyyy)
18/Mar/2021 17:51

Fax to: 905−358−4972
Telephone: 905−358−4944

Patient Information (*Affix Sticker if available)*

Last Name: _____ First name: _____

DOB: (dd/mm/yyyy) _____ Gender: ☐ M ☐ F ☐ Other

Address: _____

_____

_____

Health Card No/Version: _____ Phone: _____

Contact Person

Name (first and last) _____

Relationship to Patient _____

Phone Number _____

Reason for Referral *(Check all that apply)*

- ☐ Comprehensive geriatric assessment
- ☐ Cognition / memory assessment
- ☐ Behavioural and psychological symptoms of dementia
- ☐ Polypharmacy / medication review
- ☐ Other:
- ☐ Mobility and falls
- ☐ Osteoporosis
- ☐ Frailty
- ☐ Caregiver stress

Please attach relevant past medical and psychiatric history, medications, other specialist consultations, and discharge summaries within the past year.
The following investigations are required to expedite the referral: ***CBC, electrolytes, TSH, B12, calcium, ECG.***

Referrer Information

Primary Care Provider: _____ Billing #: _____

Address, Phone and Fax #: _____

Referring Practitioner: _____ Billing #: _____

Address, Phone and Fax #: _____

Referring Practitioner Signature: _____

We will contact patient/next of kin directly for an appointment date and location. Thank you.

Rev. 01/2021 (v1)

REF49

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