niagarahealth

Extraordinary Caring. Every Person. Every Time.

Geriatric Rapid Assessment Clinic (Geri−RAC) Referral

We are not crisis or emergency services. If your patient needs immediate help, please direct them to the nearest emergency department or call 911

Patients will be booked at next available appointment. Please only select specific site if patient has transportation restrictions.

St. Catharines Hospital
1200 Fourth Avenue
St. Catharines, ON L2S 0A9
4th Floor of the Walker Centre

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

Referral Date:
18/Mar/2021 17:51
(dd/mm/yyyy)
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 (NOK / SDM / POA)

☐ Patient consents for Geri−RAC to contact person named below

Name (First and Last) _____

Relationship to Patient _____

Phone Number _____

Reason for Referral *(Check all that apply)*

- ☐ Rapid cognitive decline (3 − 6 months)
- ☐ Behavioural or psychological symptoms not well managed
- ☐ Rapid functional decline
- ☐ Frequent falls
- ☐ Frequent ED visits or hospitalizations
- ☐ Caregiver stress
- ☐ Safety concerns (eg. abuse, driving, living alone with cognitive impairment)
- ☐ Other:

Exclusion criteria:

- ☐ Acute delirium
- ☐ Acute stroke
- ☐ Active psychiatric issue
- ☐ Long−term care patient

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

Referrer Information

Referral Source: ☐ ED ☐ GEM−NP ☐ Hospital ☐ GIMRAC

Primary Care Provider: _____ Billing # _____

Address, Phone and Fax #: _____

Referring Practitioner: _____ Billing # _____

Address, Phone and Fax #: _____

Referring Practitioner Signature: _____

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

REF50

Chart Copy − Do Not Destroy

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