Geriatric Day Hospital Referral Form

Referral Date: ________________
dd/mmm/yyyy

PATIENT LABEL if no label available

NAME: ______________________________

d.o.b.: ______________ Age: ______
dd/mmm/yyyy

Health Card: ______________ M ☐ F ☐

MRN: __________ Telephone : __________

Address: ____

City: ____________________________ Postal Code: ________________

Language of Preference: English ☐ French ☐ Other (specify): ______________

Contact Person (relationship): ______________________Telephone No.: __________

Preferred 1st contact: Patient: ☐ Other: ______________________________

Family Phys: ______________ **LHIN Case Manager**, if applicable: ______________

Other community agencies involved (please specify):

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Reason for Geriatric Day Hospital Referral:

☐ Cognition	☐ Mood	☐ Medication Review
☐ Deconditioned	☐ Decreased function	☐ Multiple Comorbidities
☐ Mobility/Falls Risk	☐ Home Safety	☐ Other______________

Brief Medical Profile: **(Please include copies of any recent diagnostics/discharge summary/labs)**

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Is the Client/Family aware of the referral to the Geriatric Day Hospital? Yes ☐ No ☐

Referral Source: GEM: ☐

Name: ____

Organization: ____

Telephone No.: ________________ Fax No.:________________

Send Referral (and accompanying documentation) to:

Geriatric Day Hospital - Fax: 613-936-4682

Cornwall Community Hospital, Level 4 East Tel: 613-938-4240 ext. 2041

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