North Simcoe Muskoka
Specialized Geriatric Services

NSM Specialized Geriatric Services Program
Central Intake Referral Form

Phone: 705-417-2192 ext. 5109 / Fax: 705-792-4614

* We do NOT provide emergency or crisis services
* Incomplete referral information will delay referral processing
* Please fax completed referrals to 705-792-4614
* Questions? Please call Central Intake at 705-417-2192 ext. 5109

Name of Patient: ____________ (*First name*) ____________ (*Surname*) ☐ **M** ☐ **F** ☐ **Other** ________

Address: ____________ (*Street Name and Number*) ______ (*Apt.*) ________ (*City*) ON (*Prov*) ________ (*Postal Code*)

Health Card #: ____________ ______ (*Version Code*) **DOB:** ________ (*dd/mm/yyyy*) **Translator required:** ☐ **Yes** ☐ **No** ________ (*Language*)

French Language Services Requested: ☐ Yes ☐ No **Aboriginal Origin:** ☐ Aboriginal Self-Identified ☐ Non-Aboriginal ☐ Unknown

Living Situation: ☐ **Lives alone** ☐ **With spouse / caregiver(s)** ☐ **Other (please identify)**

Submission of this referral form will be taken to explicitly mean that you have obtained appropriate permissions for NSM SGS program to collect, use and disclose personal health information (PHI) with circle of care health service providers to assist with the care of the referred patient. NSM SGS program will assess the needs of the referred patient and may direct referrals to a different service than requested based on the information gathered.

Patient able to provide consent for collection/use/disclosure of PHI: ☐ **Yes** ☐ **No** **Patient aware of referral?** ☐ **Yes** ☐ **No**
If no, provide Substitute Decision Maker (SDM) information as Alternate Contact.

Contact Person for Booking Appointment: ☐ **Patient** ☐ **Alternate Contact - Reason:** ____________

Alternate Contact: ____________ **Relationship:** ☐ **SDM** ☐ **Other** ______ **Tel #:** ____________

SERVICE REQUESTED

The NSM SGS program provides services to older adults residing in and able to access services in the NSM region.
NOTE: Requests for Geriatric Psychiatrist/Geriatrician require a physician or nurse practitioner referral.

☐ **Geriatric Medicine Team**

NSM SGS is working in collaboration with NSM sub-region partners to provide Geriatric Medicine services. Geriatric medicine services support frail older adults with geriatric syndromes who would benefit from a comprehensive geriatric assessment by an interprofessional team with specialized knowledge/skills in geriatric medicine. Services vary in each region based on available resources, including access to Geriatricians. Collaboration with partners to establish integrated services in all sub-regions is ongoing.

Where formal partnerships exist, the NSM SGS program will automatically redirect Geriatric Medicine referrals to the sub-region team in which the patient resides. In other NSM sub-regions, our Central Intake Team will provide the referral source with a list of sub-region service options.

☐ **Geriatric Mental Health Team**

Consultation services for seniors in the community or LTCH with a diagnosis of serious mental illness for treatment recommendations **and/or** experiencing expressive/responsive behaviour as a result of a cognitive impairment that can be related to dementia, mental illness, addictions and/or other neurological disorders.

☐ **Seniors CARE Exercise Program**

A group exercise rehabilitation program delivered by Registered Kinesiologists targeting frail older adults offered in partnership with local agencies in Barrie, Couchiching and North Simcoe. This program is offered 2 times/week for 10-12 weeks with a focus on balance, coordination and upper and lower extremity strengthening as well as health education and cognitive stimulation.

☐ As the referring MD/NP, I confirm this individual is medically clear to participate in the CARE program.

☐ **GeriMedRisk Consult**

An interdisciplinary team with expertise in pharmacy, geriatric psychiatry, clinical pharmacology and geriatric medicine that provide support in managing medication/physical/mental health issues in older adults. GeriMedRisk specialist physicians do not see the patient over phone or video, but rather provide recommendations based on the information provided. Where appropriate, GeriMedRisk conducts a best possible medication history via phone with the patient/caregiver. Written response received within a median of 5 business days.

☐ **Unsure, help me find the best service**

If available and appropriate, please attach the following information to help inform the referral:

☐ Cumulative Patient Profile (CPP)
☐ Recent labs / Diagnostic Imaging
☐ Consult Note(s)/ Specialist Report(s)
☐ Current medication list
☐ Results of previous cognitive and/or functional tests

Waypoint
CENTRE *for* MENTAL HEALTH CARE
CENTRE *de* SOINS *de* SANTÉ MENTALE

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Patient Name: ______________________________

SYMPTOMS / CONCERNS IDENTIFIED (Check all that apply)	New or Recent Decline	**PRIMARY REASON FOR REFERRAL:** *What is the main concern to be addressed? If Responsive behaviours – please describe. If new or recent decline – please describe.*
☐ **Mobility/ falls**	☐ Yes	
☐ **Incontinence**	☐ Yes	
☐ **Pain management**	☐ Yes	
☐ **Medication/ polypharmacy**	☐ Yes	
☐ **Sleep disturbance**	☐ Yes	
☐ **Weight loss /nutrition**	☐ Yes	
☐ **Parkinsonism**	☐ Yes	
☐ **ADL/ IADL decline**	☐ Yes	
☐ **Cognitive changes/ dementia**	☐ Yes	
☐ **Atypical cognitive changes**	☐ Yes	
☐ **Responsive behaviours** o **Verbal/ physical aggression** o **Other** ____________	☐ Yes	
☐ **Delusions/ hallucinations**	☐ Yes	
☐ **Suicidal/ homicidal ideation**	☐ Yes	
☐ **Anxiety/ mood concerns**	☐ Yes	
☐ **Psychotic Symptoms**	☐ Yes	
☐ **Caregiver/ family concerns**	☐ Yes	
☐ **Elder abuse/neglect suspected**	☐ Yes	
☐ **Social isolation**	☐ Yes	
☐ **Recurrent ED visits**	☐ Yes	
Other (specify):	☐ Yes	

Referral Location: ☐ Primary Care ☐ HCCSS-NSM ☐ Hospital ☐ ED ☐ Community Support Service ☐ LTCH ☐ Retirement Home

Referral Source: ☐ Physician ☐ Nurse Practitioner ☐ Self ☐ Other:

____
Organization Name

Name of Person Referring: ______________________________

Contact Numbers: ____________ Tel # ____________ Fax #

Referral signature: ____________ **Date** (dd/mm/yyyy): ____________

Primary Care Practitioner Name: ______________________________ **Billing #** ____________

Contact Numbers: ____________ Tel # ____________ Fax #
If different from above

Waypoint
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