Recommend Patient Referral to GeriMedRisk

To: _____ Date: _____

From: _____ Phone Number:_____

Site:_____ Clinical Role: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

DOB (m/d/y):_____ OHIP Number: _____

Referral to GeriMedRisk* suggested for an interdisciplinary virtual consultation on the following issue(s):

☐ Drug optimization: polypharmacy, adverse drug effects, drug interactions

☐ Review of mental health concerns (medications, BPSD)

☐ Review of complex physical condition(s) ☐ Please see attached notes

☐ Other:_____

Please provide specific details:_____

_____

☐ GeriMedRisk **has not been discussed** with the patient

GeriMedRisk Virtual Clinician-Facing Consultation Service:

- 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;
- responsive with a median of 5 business days with an integrated multi-specialty consult note.

How to consult:

1. Ontario Telemedicine Network eConsult or Champlain BASE™ eConsult: select “GeriMedRisk”
2. Fax: (519) 279-2959
3. Specialized Geriatric Services Intake Forms (regions: Champlain, Hamilton Niagara Haldimand Brant and North Simcoe Muskoka): select "GeriMedRisk"
4. Telephone: Call toll-free 1 (855) 261-0508 between 9:00 am – 5:00 pm Eastern Time

To be completed by the Primary Care Provider:

☐ I agree with and request a consult to GeriMedRisk

GeriMedRisk will contact the the patient/caregiver for a best possible possible medication history

Contact Name: _____ Phone Number:_____

☐ No, please do not contact the patient/caregiver by phone to conduct a best possible medication history.

Provider Name:_____ Phone Number:_____

Signature: _____ OHIP Billing Number: _____

Please include any relevant clinical information from your EMR with this referral form.

GERIMEDRISK