Suggest 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:_____

Specifically involving:_____

_____

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

GERIMEDRISK VIRTUAL CLINICIAN-FACING CONSULTATION SERVICE:

- An interdisciplinary team with expertise in pharmacy, geriatric psychiatry, clinical pharmacology and geriatric medicine that provides support in managing medication/physical/mental health issues in older adults.
- GeriMedRisk specialist physicians do not see the patient in person or by video, nor do they connect with them by phone, but rather provide recommendations based on the information provided. Where appropriate, the GeriMedRisk pharmacy team conducts a best possible medication history via phone with the patient/caregiver.
- After receiving relevant clinical information, the GeriMedRisk team provides interdisciplinary clinical recommendations accompanied by geriatric drug information education materials.

HOW TO CONSULT:

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

TO BE COMPLETED BY PRIMARY CARE MD/NP (IF CONSULTING GERIMEDRISK)

The GeriMedRisk pharmacy team will contact the the patient/caregiver for a medication interview:

Contact Name: _____ Phone Number: _____

Relationship to patient (if applicable): _____

Are they the patient's SDM? ☐ YES ☐ NO SDM's Contact Info:_____

☐ **No, please do not contact the patient/caregiver by phone to review their medications.**

Referring Clinician (MD/NP): Phone number:_____

Provider Name:_____ Fax: _____

I request a consult to GeriMedRisk for my patient:

Signature: _____ Registration Number:_____

****Please include any relevant clinical information from your EMR with this referral form (e.g. notes from recent visits, consult notes, etc.) that would not already be available in Clinical Connect/ConnectingON.****