GAIN
Geriatric Assessment & Intervention Network

# Referral Form

*Note: Please refer only to one Team.
The referral will be triaged to the most appropriate GAIN team

| SCARBOROUGH | | DURHAM | NORTH EAST | | |
|---|---|---|---|---|---|
| ☐ Scarborough & Rouge Hospital: *General Site*<br>T: 416-431-8111<br>Fax: 416-289-2961 | ☐ Carefirst Seniors & Community Services Association<br>T: 416-847-8941<br>Fax: 416-847-8942 | ☐ Lakeridge Health Oshawa Hospital<br>T: 905-576-8711 x 4832<br>Fax: 905-743-5311 | ☐ Port Hope Community Health Centre<br>T: 905-885-2626 x 254<br>Fax: 905-885-6063 | ☐ Trent Hills Community Team (Campbellford)<br>T: 705-653-1140 x 2139<br>Fax: 705-632-2023 | ☐ Peterborough Regional Health Centre<br>T: 705-743-2121 x 5021<br>Fax: 705-876-5058 |
| ☐ Scarborough & Rouge Hospital: *Centenary Site*<br>T: 416-281-7446<br>Fax: 416-281-7082 | ☐ Senior Persons Living Connected<br>T: 416-493-3333 x 311<br>Fax: 416-352-5086 | ☐ Carea Community Health Centre (Whitby)<br>T: 905-723-0036 x 1409<br>Fax: 905-665-7178 | ☐ Community Care City of Kawartha Lakes (Lindsay)<br>T: 705-879-4112<br>Fax: 705-880-1516 | ☐ Haliburton Highlands Health Services (Minden)<br>T: 705-286-2140 x 3400<br>Fax: 705-286-0720 | |

PATIENT NAME: _____ Date of Birth (D/M/Y): _____

Address: _____ City: _____

Phone: _____ Other Phone #: _____ Sex: ☐ M ☐ F

Health Card Number: _____ Language: _____

Contact Person/SDM/POA: (REQUIRED)

Name: _____ Relationship: _____ Phone: _____

☐ Patient has provided verbal consent for GAIN to contact Contact Person/SDM/POA

Who should we contact to book appointment? ☐ PATIENT ☐ CONTACT PERSON

REASON FOR REFERRAL: (REQUIRED)

Please Circle all that apply

1. Cognitive decline affecting hygiene, managing medication, banking, driving and/or meal preparation
2. Complex medication regimen/polypharmacy
3. Recent falls or mobility changes
4. Recent physical or functional decline
5. Responsive behaviours (agitation, wandering, paranoia, hallucinations, inappropriate behaviours)
6. Caregiver(s) having difficulty coping

Patient can attend a clinic visit ☐ Yes ☐ No Reason:

*Attach supporting documents (within last year): patient profile, med list, consults, recent labs/diagnostics
**Failure to provide required documentation will delay appointment booking**

Pharmacy: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Referred By: ☐ Primary Care ☐ GEM/ED ☐ Inpatient ☐ Specialist ☐ Family/Self ☐ Community Agency ☐ LHIN ☐ Other

Referral Source Contact information: _____ Date: _____

Billing#: _____ Signature: _____