Baycrest

Geriatric Assessment Clinic Out-Patient Referral Form
3560 Bathurst Street
Ambulatory Clinics
Fax: 416-785-2863

PLEASE FAX TO 416-785-2863 ALONG WITH RELATED CONSULTATION NOTES AND/OR RECENT LAB RESULTS

MAIN TELEPHONE: 416-785-2500 Enter Extensions Below

REFERRAL TO:

- □ First Available
- □ Dr. M. Gordon ext. 2613
- □ Dr. G. Gotesman ext. 2636
- □ Dr. T. Izukawa ext. 2621
- □ Dr. C. Ott ext. 2615
- □ Dr. B. Petrut **ext. 2636**
- □ Dr. F. Varlese ext. 2613
- □ Dr. S. Veinish ext. 2621
- □ Dr. T. Yogaparan ext. 2620

PATIENT INFORMATION

Patient's last name: First Name:			
Address:	Phone No.	Birth Date: (D-M-Y)	Sex: □ M □ F
Health Card # / VC	Preferred Language: □ English □ Other _____ Is an interpreter required? □ Yes □ No		
Contact Person:	Relation to the Patient:		
Home Phone No.:	Other Phone No.: □ Work □ Cell		
Has Patient received any medical services at Baycrest before? □ Yes □ No			

REFERRING PHYSICIAN

Physician Name:	Physician Billing Number:
Phone No.:	Fax No.:

REASON FOR REFERRAL

Main Concern(s)
PLEASE CHECK ALL THAT APPLY

- □ ADL/IADL
- □ BEHAVIOURAL DIFFICULTIES
- □ COGNITION/DEMENTIA
- □ DELIRIUM
- □ DELUSIONS/HALLUCINATIONS
- □ DEPRESSION/ANXIETY
- □ HOME SAFETY
- □ INCONTINENCE
- □ MEDICATION(S)
- □ MOBILITY/FALLS
- □ VERBAL/PHYSICAL AGGRESSION
- □ WANDERING
- □ WEIGHT LOSS/NUTRITION
- □ OTHER

_____
_____

MEDICAL INFORMATION:

Medical History – medications (*please attach current list)*