Capital Health

Geriatric Day Hospital / Falls Clinic Referral Form

Phone: (902) 473-2493 Fax: (902) 473-7336

Please print clearly and complete all sections.

❑ **Falls Referral** ❑**Regular Referral** ❑ **Letter Attached**

Name: ______________________________

Address: ______________________________

Phone#: ______________________________

Date of Birth: ______________________________

Health Card#: ______________ **Expiry:** ______________

Referral Source: ______________ **Phone:** ______________ **Fax#:** ______________

Family Physician: ______________ **Phone:** ______________ **Fax#:** ______________

Contact for Initial Appt: ______________________________

Home Phone#: ______________ **Cell/Work#:** ______________

Specific Reason for referral/description of falls:

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Medical Problems	Associated Medications

Referral Forms

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Current Functional Information				
Mental Status	☐ Normal	☐ Impaired	MMSE	/ **30**
Emotional	☐ Normal	☐ Depression	☐ Anxiety	☐ Other
Communication	☐ Normal	☐ Impaired		
Mobility	**Transfers** ☐ Independent ☐ Assisted ☐ Unable			
	Walking ☐ Independent ☐ Assisted ☐ Unable			
	☐ Aids ______			
Balance	☐ Normal	☐ Impaired	☐ Falls # ______	
Bowel / Bladder	☐ Continent	☐ Incontinent		
Nutrition	Weight_____lbs	☐ Stable	☐ Loss	☐ Gain
Activities of Daily Living	☐ Independent	☐ Assisted	☐ Unable	
Social	☐ Lives alone	☐ Lives with other: ______		
Main Social Support	☐ Family	☐ HCNS/CCNS	☐ Other	

☐ **Patient's Family Physician has been contacted and is aware of *AND* agrees with referral to the Geriatric Day Hospital/Falls Clinic.** *In the interest of integrated patient care, the patient's Family Physician must be notified of this referral by phone or by faxing a copy of this referral form to the family physician. Thank you for your attention to this.*

Signature (*Physician signature is required for MSI purpose)*			
Name (Please Print) *(If trainee, please provide attending MD name)*			
Date		**Date Received**	