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| **A close up of a logo  Description generated with very high confidence** | | | **REFERRAL FORM**  **Seniors Health and Wellness Centre** | | | |
| **Services provided at the**  **Salmon Arm Seniors Health and Wellness Centre:**   * Interdisciplinary comprehensive geriatric assessment * GP, OT, PT, RD, SW, RN, RA * Shared care planning approach * Short-term therapeutic intervention * Transitions-in-care planning at discharge | | **Referred individuals must meet the following criteria:**   * 65 years of age or older (under 65 years by exception) * CSHS Clinical Frailty Scale rating of 4-6 * Medically Complex (at risk of decline without intervention) * Potential to stabilize and/or optimize physical health and function * Agreeable for assessment/intervention   **Please check all Geriatric Syndromes that apply:**  ⬜ More than 2 falls in the past year  ⬜ Increasing balance and mobility issues  ⬜ More than 2 Emergency Department visits in the past year  ⬜ Unintentional weight loss or dysphagia  ⬜ Sub-optimal pain control  ⬜ Medication management concerns  ⬜ Troublesome Incontinence | | | | |
| Referral date: | |
| Patient’s name: | | | | | Home Phone #:  Cell Phone #: | |
| PHN: | Date of birth: (MM/DD/YYYY) | | | | Gender:  M  F | |
| Home Address: | | | | | | |
| **Living situation:**  Alone  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | **Languages spoken:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Interpreter needed | | |
| Key Family/Caregiver Contact: Consent given to contact to arrange appointments  Yes  No Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Caregiver Supportive of Participation Yes No | | | | | | |
| Med Access Profile attached Please also attach if available:  Recent lab results: CBC; Lytes; Creat; ALT, AST, TSH; B12; Ca+; A1C; ALB MOST (Medical Orders for Scope of Treatment) Yes (copy attached)  No Cognitive Testing – SMMSE, MoCA, Clock Drawing Imaging Reports – CT, MRI  Prior Assessments – Geriatric Psychiatry, Neurology, Seniors Mental Health, pertinent Specialist Reports, Home Health | | | | | | |
| Reason for Referral/Specific Request: Yes  No GP Geriatric Consult  Yes  No Consent for Medication Changes | | | | | | |
| **Referring Physician/NP:**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Office phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | **Please fax to: 778-489-5256**  Seniors Health and Wellness Centre  Suite 4, 781 Marine Park Drive  Salmon Arm, BC V1E 2X1 |