



Seniors Health Referral Form

For specialty referrals in Seniors Health, including
Geriatric Medicine & Psychiatry, &
Outreach Services (SORT, formerly VISTA & EOS)
South Island (south of Cedar)

PHONE: 250-370-8565 or 1-855-370-8565
FAX: 250-519-1904 or 1-855-519-1904

Client/Patient Information

First Name:	Last Name:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: <i>day / month / year</i>
Address or Current Care Location:		PHN:	MRN:
Home Phone:		Cell Phone:	
Can patient book own appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If No, please provide alternate contact info</i>			
Name:	Relationship:	Phone:	
Next of Kin Name:	Relationship:	Permission to contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Phone:			

Referral Information

Family Physician:	Phone:	Fax:
Referring Physician/Clinician: (if different than Family Physician)	Phone:	Fax:
Reason for Referral (please attach consult letter & all relevant test results):		
Clinical Features (for any identified as "yes" please provide additional information)		
Risk of self-harm/suicidality: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Drug or alcohol abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Urgent safety issues: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <i>Elder abuse, wandering risk, fire risk, etc.</i>	History of falls: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Cognitive issues: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If possible, provide MMSE Score_____, MoCA Score_____	Mobility issues: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Diagnosis of Dementia: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Complex Medical/Health: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Aggressive or psychotic behavior: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Current Medications:	
Mood Disorder: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Previous psychiatric involvement: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Labs & diagnostics up to date?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Physician/Clinician Signature:	Date of Referral:	
For Intake Clinician: <input type="checkbox"/> Urgent <input type="checkbox"/> Semi-urgent <input type="checkbox"/> Non-urgent Other information:		