North Bay Regional Health Centre

Nipissing Specialized Geriatric Services

Referral Form

120 King St. West, North Bay, ON. P1B 5Z7
Phone: 705-494-3054, Fax: 705-494-3097

Please note, incomplete referrals may delay intake process.

Required Referral Form to Access NBRHC's Nipissing Specialized Geriatric Services

If you have a preferred service, please check the appropriate box (*optional*):

☐ **Seniors' Mental Health** ☐ **Geriatric Medicine Clinic** ☐ **Behavioural Supports Ontario**

All information will be considered during the intake process and referrals will be triaged to the most appropriate service(s).

Patient Demographics

Name *(last, first)*: DOB (*dd/mm/yyyy*):

Gender: Health Card #: Version Code:

Preferred Language:

Address (*unit/street #)*:

City: Postal Code: Phone #:

Lives alone: ☐ No ☐ Yes If no, please specify:

Secondary Contact:

Relationship: Phone #:

Did patient/SDM consent to this referral? ☐ No ☐ Yes Comments:

Person to Contact Regarding this Referral

☐ Patient ☐ Secondary Contact ☐ Other (*if other, please specify below)*

Name: Relationship: Phone #:

Agency Involvement

☐ Home & Community Care
☐ Alzheimer Society
☐ Other (*please specify*):
☐ Mental Health Services
☐ North East Specialized Geriatric Centre

Reason for Referral

☐ Cognitive changes
☐ Behavioural changes
☐ Mood symptoms
☐ Symptoms of psychosis
☐ Suicidal/homicidal ideation
☐ Substance/Medication misuse
☐ Polypharmacy/Medication Review
☐ Caregiver/family concerns
☐ Social isolation
☐ Other (*please specify*):
☐ Mobility/falls
☐ Functional changes
☐ Incontinence
☐ Pain management
☐ Sleep disturbance
☐ Unintended changes in weight/nutrition
☐ Complex medical problems
☐ Multiple ED visits secondary to geriatric syndromes

Brief Description and Clinical Question

Office Use Only:

Date rec'd: Initial: NB#:

Previous SMH-RCS file: ☐ No ☐ Yes Previous OGMC file: ☐ No ☐ Yes Previous/Current BSO file: ☐ No ☐ Yes

Outpatient Specialized Geriatric Services- Referral Form

Name (*last, first)*:	DOB (*dd/mm/yyyy*):

Legal Concerns

Are there any legal concerns (consent, capacity, abuse, etc.)? ☐ No ☐ Yes
If yes, please specify:
Has a MTO report been completed? ☐ No ☐ Yes

Risks and/or Safety Concerns (*for patient and others*)

Relevant Medical, Surgical & Psychiatric History – *Please attach any relevant clinical information from your EMR (e.g. notes from recent visits, consult notes) that would not already be available in Connecting Ontario.*

Current Medications

☐ Please attach Medication list/CPP

Allergies

Required Investigations for Seniors' Mental Health and Geriatric Medicine Clinic Referrals
Please ensure the following recent (within the last 3 months) results are available:

☐ CBC	☐ TSH, B12
☐ HbA1c	☐ ECG
☐ Creatinine, eGFR	☐ VDRL (if risk factors)
☐ Electrolytes and calcium, albumin, magnesium, and phosphorus	☐ Serum Drug Levels (e.g. lithium or other mood stabilizers, anticonvulsants, digoxin) if applicable
☐ CT/MRI scan results (required for referrals related to cognitive changes)	☐ Completed cognitive screening assessments if available (e.g. MMSE/MoCA)

Additional Comments

Primary Care Provider:

Print Name:
Phone #: Fax # (*if applicable*):

Request for Referral Initiated by (*please specify):*

☐ Family	☐ Patient
☐ Primary Care Provider	☐ Other:

Referring Physician/Nurse Practitioner (*if different than PCP*):

Print Name:
Phone #: Fax # (*if applicable*):

Date (*dd/mm/yyyy*):		**Signature:**	

Please fax the completed form to 705-494-3097. We will contact you if we require further information or if unable to register the patient with our services.