COMMUNITY HEALTH SERVICES & GERIATRIC SPECIALTY SERVICES REFERRAL

Contact the Community Access Centre for Nanaimo and area:	(250) 739-5748 or (1-877) 734-4141	**Fax form to:**	(250) 739-5751 or (1-877) 754-2967

Client Information:

Last Name:	First Name:	
Address: *(incl. postal code)*		
Date of Birth: *(dd/mm/yy)*	PHN:	
Client Home Phone:	Client Cell Phone:	
Alternate Contact & Relationship to Client:	Alternate - Home Phone:	Alternate - Cell Phone:

Family Physician Name:
Address:
Phone:
Fax:

Referral Information:

Reason for Referral: *Comment on functional or clinical need and desired outcome. Indicate if physician-to-physician request for Geriatric Specialty Services:*

Additional for Geriatric Specialty Services *only*: *Indicate assessments and/or treatments tried and diagnostics completed to rule out other causes:*

☐*or Referral Letter Attached*

Pertinent/Relevant Medical History: *List recent or new diagnoses, MOST, PPS, etc.:*

Clinical Features: *Describe behavioral or cognitive issues, risk of self-harm, falls, aggression, anxiety, pain, etc.:*

Home Situation: *Outline if living alone, caregiver status, environmental risks, social issues, abuse or neglect, etc.:*

Community Access contacts all clients at time of referral:

☐ Contact client ☐ Contact family/caregiver/alternate ______________________________

Collateral Information to be included with the referral:

☐ Allergies	☐ Current medication list	☐ Consults not on Cerner / Powerchart	☐ Patient Medical Summary
☐ Diagnostics*	☐ Labs*	☐ MOCA / MMSE / cognitive screening	☐ Scales / scores (e.g. Frailty)

* For Geriatric Specialty Services referral, the following are required: CBC and diff, Na,K,creat, eGFR, Ca++,albumin, +/-protein, GGT, AST +/-Alk phos, TSH, Serum B12, and CT head only if done previously. **If lab results or diagnostic collateral is not being provided, *please indicate why*:**

Date of Referral:	Referral Source: *please print name*	Referral Source Signature:

*** **Please see reverse page** for more detailed information on how to complete this form ***

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Community Health Services provides a wide range of professional services in the community and in client homes, depending on the client's assessed care need and urgency of need. Services may be short-term if your client is recovering from a procedure or condition or long-term if the client needs ongoing care. For further details of services provided, please visit www.viha.ca/hcc/services/

Geriatric Specialty Services includes specialized care for seniors who are generally complex with unstable, often co-morbid psychiatric and/or medical issues, frailty and/or functional decline. Referrals for a Geriatric Psychiatrist or Geriatrician must come from a physician. The specialists do work within an interprofessional team to assess and manage complex psychiatric and medical conditions for elderly clients. Please refer to the *Pathways* site for details on inclusion/exclusion criteria.

How to Complete this Form:

Reason for Referral:

Describe:

- Indicate client need with specific medical, functional, cognitive and/or social concerns with some timelines of when these changes started occurring
- Describe the urgency of client situation
- For Geriatric Specialty Service referrals, indicate the specific clinical need that requires assessment and/or treatment recommendations

Additional for Geriatric Specialty Services *only:*

Provide:

- Information on any diagnostics and assessments completed to rule out other causes for clinical presentation
- Information on any pharmaceutical treatments already trialed

Relevant/Pertinent Medical History:

Indicate:

- Recent or new diagnosis
- Relevant medical history that impacts current clinical presentation
- If MOST (Medical Orders for Scope of Treatment) order has been developed, include copy
- Palliative Diagnosis: include PPS score

Clinical Features:

Describe:

- Behavioral features: Aggression (verbal or physical), wandering, socially inappropriate (include intensity and frequency (eg. episodic to daily occurrence)
- Mood Disturbance or Anxiety including intensity and duration (eg. episodic to daily occurrence)
- Cognitive changes (e.g. memory, executive functioning, word finding, processing, etc.)
- Falls and/or physical weakness
- Pain issues (describe intensity and frequency)

Home Situation:

Provide any information on:

- Safety issues, including environmental and social risks set up
- Abuse, neglect or self-neglect concerns
- Caregiver status
- Capacity to continue living in current environment

Collateral Information:

- A current medication list including over the counter medications, supplements and vitamins and allergy list is **REQUIRED**
- For Geriatric Specialty Service referrals, labs **REQUIRED**: CBC and diff, Na,K,creat, eGFR, Ca++,albumin, +/-protein, GGT, AST +/-Alk phos, TSH, Serum B12
- CT Head if done previously