Provincial Geriatric Program
243 Heather Moyse Drive
Summerside, PE C1N 5R1
Phone: (902) 432-2860 Fax: (902) 432-2859

Referral Form

Please ensure **ALL** information is included and mail or fax to the above address.

APPT LOCATION ☐ Office ☐ Home visit ☐ Care facility: Specify_____________________
☐ Hospital: Specify___________________

Name ____
(Surname) (Given Name) (Middle initial)

Address____ Postal code _______________

____

Phone Number________________ PHN _______________ DOB ________________
Day / Month / Year

Marital Status _________ Sex ☐ Male ☐ Female

Contact Person ________________ Relationship ___________ Phone ______________

(Important to include contact person for collateral history)

Who should be contacted with appointment? ☐ Patient ☐ Contact person

Physician to complete

Has this referral been discussed with the patient? ☐ Yes ☐ No

REASON FOR REFERRAL: ☐ Dementia ☐ Delirium ☐ Depression ☐ Frailty ☐ Falls
☐ Driving concerns ☐ Medication error/review ☐ Home Safety ☐ other_______________

Relevant History____

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Other services involved: ☐ Home care ☐ Social work ☐ Others___________________

Investigations: Head CT: ☐ Attached ☐ Pending ☐ Not arranged

ECG: ☐ Attached ☐ Pending ☐ Not arranged

Bloodwork: ☐ Attached ☐ Pending ☐ Not arranged

(CBC, Cr, lytes, BUN, AST, ALT, ALP, CK, Total Bilirubin, TSH, vit B12, Calcium, Albumin)

Please attach any other relevant information

Referring physician:___________________ **Tel**:___________________ **Fax**:________________

Physician signature:_________________________________ **Date**:_________________

Revised January 2010