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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 [ ]  NoName:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Caregiver Supportive of Participation **[ ]** Yes **[ ]** No |
| [ ]  Med Access Profile attachedPlease 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 CentreSuite 4, 781 Marine Park DriveSalmon Arm, BC V1E 2X1 |