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ST. MICHAEL'S HOSPITAL
A teaching hospital affiliated with the University of Toronto

GERIATRIC INTERNAL CONSULTATION TEAM (RGP)
REFERRAL FORM

Date of Referral: _____ Time: _____ Location: _____ Room_____

Patient Name: _____J # _____

Referral Source: _____Staff MD: _____

Primary Diagnosis/Main Concern: _____

Reason(s) for Referral:

1. ❒ Geriatric Consultation regarding any of the following issues *(please check all appropriate boxes)*:
   - ❒ cognitive changes (acute/chronic)
   - ❒ falls/mobility
   - ❒ continence issues
   - ❒ unexplained functional decline
   - ❒ review of complex medication issues
   - ❒ complex psychosocial issues
   - ❒ decision-making ability related to treatment options
   - ❒ other (please specify) _____
2. ❒ Possible admission to the Acute Care of the Elderly Unit (ACE).
3. ❒ Collaboration/consultation regarding geriatric rehab. potential.
4. ❒ Post discharge follow-up planning (i.e. Elder's Clinic appointment).

Comments:

Name of Referring MD _____ Pager: _____

FAX consultation request to 416-864-5735

Regional Geriatric Program (RGP) office - Ext. 5015