

Intake & access of referrals are managed by Huron Perth Healthcare Alliance. All listed organizations may receive the patient's personal health information as necessary to determine the most appropriate geriatric service(s), in compliance with the Personal Health Information Protection Act (PHIPA)

- Seniors Mental Health, Huron Perth Healthcare Alliance (Behavioural Supports Ontario Mobile Team)
- Geriatrician – Dr. Alexandra Peel & Listowel Wingham Hospitals Alliance
- Alzheimer Society Huron Perth
- Huron Perth Geriatric Resource Nurses (GRNs), St. Joseph's Health Care London

Date of referral:
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**PATIENT INFORMATION**

Last name	First name	Age	Pronoun:	Language:
Address:		Phone # 1: Phone # 2:	Patient/SDM consent for referral? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Health card (including version code)	Date of birth: <small>YYYY/MM/DD</small>	<b>Person to contact:</b> <input type="checkbox"/> Patient <input type="checkbox"/> Alternate contact		

**ALTERNATE CONTACT**

Name:	Relationship to patient:	Is the alternate contact the SDM? Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>	Phone number:
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**PRIMARY REASONS FOR REFERRAL (check all that apply)**

<input type="checkbox"/> Memory concerns/cognition/personality change <input type="checkbox"/> Medical complexity & frailty <input type="checkbox"/> Mental health assessment/psychiatry <input type="checkbox"/> Medication review/polypharmacy <input type="checkbox"/> Mobility & falls/functional decline <input type="checkbox"/> Movement disorders (e.g. Parkinsonism) <input type="checkbox"/> Driving concerns <input type="checkbox"/> Caregiver support/education & dementia resources <input type="checkbox"/> Responsive behaviours with dementia, mental health addictions (BSO) - <b>specify behaviours:</b>	<input type="checkbox"/> Local memory clinic assessment? Yes <input type="checkbox"/> No <input type="checkbox"/> <b>PLEASE ATTACH MOST RECENT</b>  <input type="checkbox"/> Home visit <b>REQUIRED (specify why):</b>  <input type="checkbox"/> <b>ACTIVE</b> Safety concerns ( <b>specify</b> ): <input type="checkbox"/> <b>ACTIVE</b> Risk of harm to self/others: <input type="checkbox"/> Recurrent hospitalizations/ED visits:
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**PRIMARY CLINICAL QUESTION/CONCERN      WHAT MATTERS MOST TO YOUR PATIENT?**

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**ATTACH - to assist with timely review of referral: please include ALL previous memory clinic recommendations, including copies of cognitive/mood testing, health history & medication list, all initial work-up - relevant labs, imaging**

**REFERRAL SOURCE**

Name (PRINT):	Physician/Nurse Practitioner SIGNATURE		
Name of Organization (eg.FHT, OHaH, CMHA)	x _____ If verbal order, taken by:		
Contact #:	Office Address:		
Primary Care Provider (if not referrer):	Phone:	Fax:	
	Billing number:		

In partnership with regional geriatric services, we provide navigation support to additional geriatric services not available locally. If your patient requires access to additional ambulatory geriatric services not available locally, the referral will be automatically forwarded to the geriatric service by the Huron Perth Healthcare Alliance. Huron Perth Healthcare Alliance will notify the referring provider if this occurs.