GAIN
Geriatric Assessment & Intervention Network

Referral Form

*Note: The referral will be triaged to the most appropriate GAIN team

SCARBOROUGH		DURHAM	NORTH EAST		
☐ **Scarborough Health Network: *General Site*** T: 416-431-8111 Fax: 416-289-2961	☐ **Carefirst Seniors & Community Services Association** T: 416-847-8941 Fax: 416-646-5111	☐ **Lakeridge Health Oshawa Hospital** T: 905-576-8711 x 34832 Fax: 905-743-5311	☐ **Port Hope Community Health Centre** T: 905-885-2626 x 254 Fax: 905-885-6063	☐ **Trent Hills Community Team (Campbellford)** T: 705-653-1140 x 2139 Fax: 705-632-2023	☐ **Peterborough Regional Health Centre** *(includes **both** a **hospital** & **community** team)* T: 705-743-2121 x 5021 Fax: 705-876-5058
☐ **Scarborough Health Network: *Centenary Site*** T: 416-281-7446 Fax: 416-281-7082	☐ **Senior Persons Living Connected** T: 416-493-3333 x 311 Fax: 416-352-5086	☐ **Carea Community Health Centre (Whitby)** T: 905-723-0036 x 1409 Fax: 905-665-7178	☐ **Community Care City of Kawartha Lakes (Lindsay)** T: 705-879-4112 Fax: 705-880-1516	☐ **Haliburton Highlands Health Services (Minden)** T: 705-286-2140 x 3400 Fax: 705-286-0720	

PATIENT NAME: ______________________________ Date of Birth (D/M/Y): ____________

Address: ______________________________ City: ____________

Phone: ____________ Other Phone #: ____________ Gender: ☐ M ☐ F

Health Card Number: ____________________

Who should we contact for this referral?

☐ **PATIENT** ☐ **ALTERNATE:** ☐ **Patient has provided verbal consent for GAIN to contact alternate**

Alternate Contact Person: ____________ Relationship: ____________ Phone: ____________

REASON FOR REFERRAL:

1. Cognitive decline affecting hygiene, managing medication, banking, driving and/or meal preparation ☐ Y ☐ N
2. Complex medication regimen ☐ Y ☐ N
3. Recent falls or mobility changes ☐ Y ☐ N
4. Acute physical decline ☐ Y ☐ N
5. Responsive behaviours (agitation, wandering, paranoia, hallucinations, inappropriate behaviours) ☐ Y ☐ N
6. Caregiver(s) having difficulty coping ☐ Y ☐ N

ADDITIONAL ISSUES/CONCERNS:

Patient can attend a clinic visit ☐ **Yes** ☐ **No** **Reason:** ____________________

PHARMACY: ____________ Phone: ____________ Fax : ____________

PRIMARY CARE PROVIDER: ____________ Phone: ____________ Fax: ____________

Other Community/Geriatric Services involved: ____________________

***Attach supporting documents: patient profile, med list, consults, recent labs/diagnostics**

____________________ ____________________

Referral Source (Physician, Family, ED/GEM, In patient etc) *Name (& Billing #)*

____________________ ____________________

Contact Phone # *Date*