Alberta Health Services

Last Name	
First Name	
PHN#	MRN#
Birthdate *(dd-Mon-yyyy)*	Physician

Specialized Geriatrics Outpatient Referral

Missing or incomplete information will delay processing. Ensure a referral letter is attached and contact name of a person who will assist the client to the appointment.

Client Demographics

Last Name	First Name	
Gender ☐ Male ☐ Female	Date of Birth *(yyyy-Mon-dd)*	Personal Health Care Number
Address	City	Postal Code
Home Phone	Alternate Phone	Is this patient able to book his/her own appointment? ☐ Yes ☐ No, complete information below ▼
Contact Person	Phone	Relationship

Referring Source

Referring Source	Phone	Fax	PRACID Number
Name of Family Physician *(if different from referring source)*	Phone	Fax	

Referring Program Area
☐ Community Care Services *(e.g. Home care)* ☐ Emergency Department ☐ Other *(specify)* _____

Reason for Referral *(main concern)*

Service Requested *(check all that apply)*
☐ Urgent appointment requested
☐ Complex co-morbidities
☐ Cognitive Assessment
☐ Medication Review
☐ Phone Consultation with Triage Nurse
☐ Other *(specify)* _____

Clinical Information *(check all that apply)*
☐ Behaviour Changes
☐ Depression/Anxiety
☐ Caregiver Stress
☐ Mobility Problems/Gait/Balance
☐ Incontinence/Urine/Stool
☐ Weight Loss

Consultation Required
☐ Consult only
☐ Consult and Follow Up
☐ Consult and Arrange Community Management

Is this patient currently medically stable? ☐ Yes ☐ No

Is the patient at risk for hospitalization? ☐ Yes ☐ No

Providers/Services Involved with Care/Consults *(attach relevant past medical history, consults, medications, lab work, etc. if unavailable on netCARE*
☐ Community Care Services *(e.g. Home Care)* ☐ Mental Health ☐ Supportive Living
☐ Community Health Services *(e.g. Public Health)* ☐ Day Program
☐ Previous Geriatrics Assessment Date *(yyyy-Mon-dd)* _____ Location _____
☐ Previous Neurocognitive Assessment Date *(yyyy-Mon-dd)* _____ Location _____
☐ Pending Medical Consults *(please list and specify times)* _____

Special Requirements
☐ Requires oxygen
☐ Hearing, visual impairment, homebound, etc. *(specify)* _____
☐ Activity limitations *(e.g. walker, cane, etc.)* _____
☐ Unable to speak/read/comprehend English *(specify language spoken)* _____
Name of translator _____ Phone _____

Please fax completed form to Alberta Health Services Central Access - Edmonton Zone
Fax - 780.735.3553 Toll free fax - 1.866.979.3553 Phone - 780.401.2665