



Referral Form

Please refer only to **one** Team.
The referral will be triaged to the most appropriate GAIN team

SCARBOROUGH		DURHAM	NORTH EAST	
<input type="checkbox"/> Scarborough Health Network: General Site T: 416-431-8111 F: 416-289-2961	<input type="checkbox"/> Carefirst Seniors & Community Services Association T: 416-847-8941 F: 416-646-5111	<input type="checkbox"/> Lakeridge Health Oshawa Hospital T: 905-576-8711 x 34832 F: 905-743-5311	<input type="checkbox"/> Port Hope Community Health Centre T: 905-885-2626 x 254 F: 905-885-6083	<input type="checkbox"/> Peterborough Regional Health Centre (PRHC) <CLINIC>
<input type="checkbox"/> Scarborough Health Network: Centenary Site T: 416-281-7446 F: 416-281-7082	<input type="checkbox"/> Senior Persons Living Connected T: 416-493-3333 x 311 F: 416-352-5086	<input type="checkbox"/> Durham Community Health Centre (Oshawa) T: 289-509-0601 F: 905-665-7178	<input type="checkbox"/> Hailburton Highlands Health Services (Minden) T: 705-286-2140 x 3400 F: 705-286-0720	<input type="checkbox"/> PRHC <HOMEBOUND> T: 705-743-2121 x5021 F: 705-876-5058

Name of Client: _____ Last name _____ First name _____ DOB: _____ Language: _____

Address: _____ Street Address _____ City _____ Province _____ Postal Code _____ Gender: _____

Phone: _____ Other phone: _____ Health Card # _____ Version Code _____

Contact Person/SDM/POA (REQUIRED): Who should we contact to book appointment? Patient Contact Person

Patient has provided verbal consent for GAIN to contact **CONTACT PERSON/SDM/POA**

Name: _____ Relationship: _____ Phone: _____

Reason(s) for Referral* (REQUIRED):

***EXCLUSION Criteria:**

- Primary referral reason:
- ❖ Active alcohol/substance misuse
- ❖ Traumatic brain injury
- ❖ Developmental disorder
- ❖ Genetic/chromosomal syndrome
- ❖ End of life care (refer to Palliative Care Services)
- ❖ Capacity assessment
- Under 65 years old (except for suspected dementia)
- Unmanaged or inadequately managed major psychiatric illness
- Long-term care residents

Attach supporting documents (REQUIRED): patient profile, consults (i.e., geriatrics, psychiatry, neurology), previous cognitive tests, recent labs/diagnostics

Geriatric Health Status (REQUIRED completed by referring clinician): (select one)

The person's medical conditions are understood and managed; their symptoms may limit some activities, but they are not dependent on others to complete their daily activities

The person has complex co-morbid diagnoses; they may need some or complete assistance with instrumental activities of daily living (e.g. finances, household) and/or personal care (e.g. bathing, dressing)

The person is bedbound from associated multiple co-morbidities

Primary Care Provider: _____ Phone: _____ Fax: _____

Referred by: Primary Care GEM/ED Inpatient Specialist Family/Self Community Agency HCCSS Other

Referral Source Name: _____ Phone: _____ Fax: _____

Billing Number: _____ Signature: _____ Date: _____

Incomplete or illegible referrals will be returned to you for completion