Vancouver Coastal Health
Promoting wellness. Ensuring care.

West Community Health Centre
#241 – 2121 Marine Drive, West Vancouver, BC V7V 4Y2
Tel 604-904-6200 x 4112• Fax 604-913-0066

REFERRAL FOR COMMUNITY GERIATRIC SERVICES

NOTE: WE ARE NOT AN EMERGENCY SERVICE

Name of Client_____ _____ ☐Male ☐Female
Last Name *First Name*

Address _____ _____ _____
Suite Street Address *Postal Code* *City*

Phone #_____ Lives Alone? ☐Yes ☐No Martial Status _____

Health Care Number _____ Date of Birth _____

Alternate Contact _____ Relationship _____ Phone # _____

Contact Person for Booking Appointment? ☐Client ☐Alternate Contact

Urgent? ☐Yes ☐No **Is Patient Homebound? ☐Yes ☐No**

Reason for Urgency: _____

We cannot triage or book this patient until we have received the following:

☐ Blood Work Results in the Past Year
☐ Imaging Reports
☐ Previous Neurological, Geriatric or Psychiatric Assessments
☐ Current List of Medications
☐ Referring Physician's Reports/Notes/Exams in the Past Year

REASON(S) FOR REFERRAL ☐Weight Loss/Nutrition ☐Wandering

☐**Medical/Physical**
- ☐Mobility
- ☐Falls

☐**Incontinence**
- ☐Pain Management
- ☐Medication
- ☐Sleep

☐**Cognitive/Behavioural**
- ☐Delirium/Dementia
- ☐Delusions/Hallucinations
- ☐Verbal/Physical Aggression
- ☐Depression
- ☐**Other:**_____

☐**Psychosocial**
- ☐Caregiver/Family Issues
- ☐Neglect/Abuse
- ☐Social Isolation
- ☐**Functional** ☐ADL/IADL Decline

MEDICAL INFORMATION- Main Concern(s) to be Addressed:

MEDICAL HISTORY: ***Please Attach***

Name of Family GP:_____ Tel:_____ Fax:_____

Name of Referring Physician:_____ Tel:_____ Fax:_____

Signature of Referring Physician:_____ Billing #_____ Date:_____