



St. Paul's Hospital  
1081 Burrard Street,  
Vancouver, BC V6Z 1Y6

**ELDER CARE AMBULATORY SERVICES REFERRAL**

Phone: 604-806-9827 Ext: 63415 Fax: 604-806-8390

Referral Date:	Referral Source:	Contact #:
<b>Patient's Name:</b>	DOB: (mmm/dd/yy)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Patient's Home Address:	Phone No: _____	PHN: _____
	Veteran Affairs Canada (VAC) #: _____	
Language(s):	<b>Living situation:</b>	
<input type="checkbox"/> Interpreter needed:	<input type="checkbox"/> Alone <input type="checkbox"/> Family _____	
	<input type="checkbox"/> Other _____	
	<input type="checkbox"/> Facility _____	
<b>Key Family Contact:</b>		
Name: _____	Phone Number(s): _____	
Relationship: _____	_____	
<b>Family Physician:</b>		
Name: _____	Date last seen: _____	
Office Phone No: _____	Billing No: _____	
Private Phone No: _____	_____	
Fax No: _____	_____	
<b>Other Physicians/Agencies Involved:</b> _____		

**Reason(s) for Referral** *(may relate to medical, mobility, rehabilitation, joint & bone, cognitive, nutritional, bowel & bladder, or family, functional or social issues)*

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**To Complete this Referral:**

1. Choose an appropriate ambulatory service located on the reverse side.
2. Attach copies of ALL relevant office notices including current drug therapy, allergies, results of investigations and other consultations.
3. Attach bone densitometry measurement results performed within the past 2 years. *(specific to Falls Clinic)*
4. Provide specific information including events, behavior or issues that prompted this referral. *(especially important for referrals for financial or personal competency assessment)*
5. FAX this form and all other appropriate material to St. Paul's Hospital Elder Care Ambulatory Services.

**FAX TO: 604-806-8390**

**SPH Ambulatory Care Services to retain this referral in the patient permanent record.**





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Patient's Name: \_\_\_\_\_

**Please request the most appropriate ambulatory service.**

Ambulatory Service	Criteria
<input type="checkbox"/> Geriatric Medicine Clinic	<input type="checkbox"/> Patient requires comprehensive initial assessment by a Geriatrician and Occupational Therapist/Case Manager relating to new or unstable conditions. <input type="checkbox"/> Patient is <b>willing</b> to attend a 2 hour initial assessment with maximum weekly follow-up frequency by Physiotherapist or as needed by MD, Occupational Therapist, Registered Dietitian, continence RN. <input type="checkbox"/> Patient does not require transport or extensive nursing or rehabilitation services.
<input type="checkbox"/> Geriatric Day Hospital	<input type="checkbox"/> Patient requires management or optimization of complex co-morbidity, activation/rehabilitation for functional impairment and assessment and monitoring by a Geriatrician <b>and</b> at least two other disciplines. (RN, Social Work, Physiotherapy, Occupational Therapy, Registered Dietitian) <input type="checkbox"/> Patient is <b>willing</b> to attend twice weekly for 6–12 weeks. (transport is provided by Day Hospital Program)
<input type="checkbox"/> Falls Clinic	Patient must meet at least <b>one</b> of the following: <input type="checkbox"/> 2 or more falls in the past year <input type="checkbox"/> 1 indoor fall in the past year <input type="checkbox"/> At least one presentation for medical attention due to a fall <input type="checkbox"/> Documented gait and balance deficits (e.g. <i>can't stand from a chair without arms, timed up and go is more than 15 seconds, obvious gait abnormalities</i> ) <b>AND</b> meet <b>all three</b> of the following <input type="checkbox"/> Age 70 or older (patients aged 65-69 will be triaged on a case by case basis) <input type="checkbox"/> No significant cognitive impairment <input type="checkbox"/> Patient <b>willing</b> to attend a 3 hour clinic assessment <b>Bone Densitometry Measurements (BDM)</b> completed within past 2 years? <input type="checkbox"/> Yes, a copy of the report is attached <input type="checkbox"/> No, but I have made arrangements for this with copies to the Falls Clinic. Appointment Date: _____

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