

Referral Form

Please refer only to **one** Team.

The referral will be triaged to the most appropriate GAIN team

GREY shaded teams provide on-site visits only (patients who are homebound should be referred to the unshaded teams)
(Note: GAIN does not provide emergency or crisis management services)

| 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"/> Community Health Centres of Northumberland T: 905-885-2626 x 254 F: 905-885-6063 | <input type="checkbox"/> Trent Hills Community Team (Campbellford) T: 705-653-1140 x 2139 F: 705-632-2023 | <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"/> Community Care City of Kawartha Lakes (Lindsay) T: 705-879-4112 F: 705-880-1516 | <input type="checkbox"/> Haliburton 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: _____

| | |
|--|--|
| <p>Reason(s) for Referral* (REQUIRED):</p> <p><i>Attach supporting documents (REQUIRED): patient profile, consults (i.e., geriatrics, psychiatry, neurology), previous cognitive tests, recent labs/diagnostics</i></p> | <p>*EXCLUSION Criteria:</p> <ul style="list-style-type: none"> • Primary referral reason: <ul style="list-style-type: none"> ❖ 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 |
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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, housework) 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